EXHIBIT # 9
DATE 1/23/13

MONTANA DPHHS
Healthy People Healthy Communities.
Department of Public Health & Human Services

# Department of Public Health and Human Services

Developmental Services Division ♦ Sanders Building, Room 307 ♦ Helena, MT 59604 ♦ fax: 406-444-5913

Steve Bullock, Governor
Richard H. Opper, Director

January 27, 2013

Representative Ron Ehli, Chair

Appropriations Subcommittee for
Health and Human Services
State Capitol Building
Helena, MT 59620

Dear Chairman Ehli:

The following responses are being provided to answer questions asked by subcommittee members during Department of Public Health and Human Services presentations by the Developmental Disabilities Division.

**Question from Senator Caferro: What is the cost per year for the PRTF Waiver?**

The PRTF Waiver paid for $1,782,003 in claims for 170 kids in the 5 years from 10/1/07 – 9/30/12. There could still be a few outstanding claims since providers have 365 days to bill. The average cost per kid for the PRTF waiver was $10,482. The kids did still receive regular State Plan Medicaid claims.

**Question from Senator Caferro: What outcome data was sent to CMS from the five year Demonstration Waiver Program?**

CMS required a Minimum Data Set (MDS) be sent to its Evaluation contractor, IMPAQ International. The MDS included basic demographic data, service utilization, youth and family satisfaction, fidelity measures if applicable, and functional outcome measures (Montana submitted scores from the Child Behavior Checklist or CBCL). This data was submitted to IMPAQ directly with a secure transmission format from a database maintained by a contractor, resulting in Montana not receiving this data at the same time. At the end of the fourth year of the grant, IMPAQ issued its final evaluation report.

The goal of the Demonstration Waiver Program was to answer two questions for Congress: 1) was the program effective in improving or maintaining a child's functional level, and 2) was providing coverage of home and community based alternatives to psychiatric residential treatment cost effective? The primary evaluation strategy was to compare outcomes before program implementation with outcomes for the same group after implementation. States measured participants' functional assessments at baseline, 6-month intervals, and disenrollment. IMPAQ used a sample size of more than 2000 records collected from nine states. The evaluation data was considered in the aggregate, after identifying the common measures available from the three functional assessment tools used by the nine states. These measures

included school functioning, substance abuse, juvenile justice involvement, and involvement with child protective services.

The findings from the evaluation data were as follows:

1. Overall the Demonstration Waiver consistently enabled youth to maintain their functional status while in the program. In many instances, program participants improved level of functioning in several areas. Furthermore, outcomes appeared to improve over time.
2. There is strong evidence the Demonstration waiver costs substantially less than the institutional alternatives. Over the first three years across all states, waiver costs were no more than 31 percent of the average per capita total Medicaid costs for services in institutions, with an average savings of $40,000 per youth.
   Just as encouraging, enrollees and their families were very satisfied with the waiver program and their level of involvement.

Montana did collect its own data independently during the same period we participated in the federal evaluation. Attached is a sample of the information we collected on the 72 participants who received waiver services as of April, 2011. The last chart, which displays the type and number of Adverse Childhood Events (ACE) as reported, indicates these youth have experienced many difficult things in their short lives, and have complex and intensive needs.

Montana's claims data indicates that youth who have at least one stay during the year in either a psychiatric residential treatment facility (PRTF) or a therapeutic group home (TGH) have average Medicaid mental health costs of over $55,000 annually (includes **all** mental health costs). The average cost for all mental health services for a youth enrolled in the Demonstration Waiver program for 12 consecutive months was $25,000, based on average expenses of $2,100 per month ($1,300 of which was for the waiver services). However, the average time a youth actually spent in the wavier was about six months. The total mental health costs of youth in the waiver from the first date of enrollment through a 12 month period averaged $35,000, increasing their cost of care by using more services or more expensive services.

While in the waiver, all youth received High Fidelity Wraparound facilitation (HFWA). This service, plus nine others, accounted for 62% of the mental health expenditures of enrolled youth, while the mental health services available to all youth comprised the other 38%. Youth do not "give up" other home and community based mental health services unless the service duplicates a waiver service they are receiving. We expect youth enrolled in Montana i-home will be similar to those in the waiver and cost the same or less than those served in PRTFs or TGHs, while being allowed to stay in their homes and communities.

**Request from Senator Caferro: Please give the committee a copy of the Child and Adolescent Needs and Strengths (CANS) assessment.**

The CANS is not a single document. The CANS developer, John Lyons, encourages the assessment tool to be customized by the system that will use it. Montana's agencies and providers have chosen to use a "comprehensive" CANS with a trauma-focus. A copy of the MT CANS reference guide is included in your handouts and the MT CANS practice manual will be sent to the Subcommittee electronically—the document is 85 pages.

While John Lyons has not made the CANS a proprietary tool and receives no royalties from its use, there are costs associated with the CANS. CANS users must be trained to understand the intent of each of the 110 questions to achieve inter-rater reliability and consistency in CANS scores. To date, about 80 people have attended CANS training in Montana, and some have attended additional training to become trainers themselves. The initial training and "train the trainer" sessions have been conducted by a consultant approved by Dr. Lyons. Eventually, there will be enough trainers located in agencies and around the state to provide CANS training to those who will administer the tool. The CANS data will be entered into an electronic storage system which will be able to generate reports at the individual user level, at the provider level, and at the state level. Some provider types may be able to receive additional reimbursement for completing the CANS when the service has an unbundled rate.

**Question from Representative Noonan: Please provide details on the waiting list for exiting MDC.**

There is one pending placement with a tentative placement date of 2/1/13.

There are 3 to 4 providers currently looking at 6 or 7 people but no proposals have been received from them as of this date.

There are 25 people referred for placement. The oldest referral is from 11/27/07 and the newest is 1/24/13. The average time on the waiting list for the people currently referred is 14 months.

**Question from Representative Hagstrom: How many individuals does the division serve who have a dual mental health and developmental disability diagnosis?**

For FY 2012 there are a total of 1,183 clients who are receiving both mental health and developmental disability services. This is 43% of the total list of waiver clients.

**Request from Senator Caferro: Please provide a copy of the MDC transformation plan.**

Will send to the Subcommittee electronically

**Question from Senator Caferro: What is the cost of the MDC fence?**

The project in question, "Install Perimeter Fence" at the Montana Developmental Center in Boulder is being managed by the Architecture and Engineering Division. The project was bid on 12/04/12 and awarded to the lowest responsible bidder for $160,360 on 12/17/12. Under separate contract, the main entry gate was awarded on 01/09/13 for $24,995.50. The perimeter fence is one of several improvements planned or in progress for the MDC physical environment.

**Question from Senator Webb: What is the service expenditure per year since 2008 by year for CHMB and DDP?**

**CMHB:**

| Service Expenditure | 2008 Expenditures | 2010 Expenditures |
|---|---|---|
| CSCT | $12,404,522 | $21,673,364 |
| Therapeutic Group Home | $17,247,286 | $16,319,981 |
| PRTF | $12,606,453 | $13,231,297 |
| Therapeutic Family Care | $6,627,561 | $9,275,927 |
| Community Mental Health Center | $4,999,670 | $6,148,088 |
| Case Management | $4,898,168 | $5,026,429 |
| Inpatient Hospital | $2,534,791 | $4,625,410 |
| LCPC | $2,292,962 | $2,907,506 |
| Physicians | $463,749 | $2,292,974 |
| Outpatient Hospital | $1,494,632 | $1,566,107 |
| Social Workers | $878,025 | $1,239,405 |
| Psychological Services | $2,380,546 | $515,633 |
| Mid-Level Practitioners | $304,765 | $329,719 |
| FQHC | $240,302 | $254,558 |
| PRTF Waiver (HCBS) | 0 | $180,000 |
| Rural Health Clinics | $105,936 | $139,691 |
| Personal Care | $108,652 | $108,617 |
| Other | $16,038 | $26,881 |
| Total | $69,604,058 | $85,861,587 |

**DDP**

| Service Expenditure | 2009 Expenditures | 2010 Expenditures |
|---|---|---|
| Group Living | $35,537,722 | $38,904,847 |
| Group Work/Day | $19,456,297 | $20,598,681 |
| Individualized Living | $15,722,176 | $16,667,004 |
| Individualized Supports | $760,259 | $787,458 |
| Individualized Work/Day | $1,101,833 | $1,102,019 |
| Personal Services | $2,744,614 | $3,079,577 |
| Self-Directed Services | 0 | $232,454 |
| Therapies | $639,359 | $839,324 |
| Transportation | $2,532,595 | $2,587,716 |
| Waiver Children's Case Management | $975,176 | $1,163,308 |
| Case Management | $3,689,243 | $3,635,165 |
| Children's Autism Waiver | $78,467 | $1,256,432 |
| Community Supports Waiver | $1,980,696 | $1,962,346 |
| Evaluation & Diagnostic Services | $936,037 | $1,002,744 |
| Part C Early Intervention | $5,179,462 | $4,442,445 |

| | | |
|---|---|---|
| FES Title XX | **$1,325,461** | **$2,112,078** |
| Medicaid Admin | **$29,003** | **$29,583** |
| Other Contracts | **$826,118** | **$497,129** |
| PASARR | **$132,106** | **$153,279** |
| Montana Developmental Center | **$15,740,861** | **$15,347,706** |
| Grants | **$3,471,242** | **0** |
| Total | **$112,858,727** | **$116,401,295** |

**Question from Representative Noonan: Please provide a copy of the Board of Visitor's Report.**

Document attached

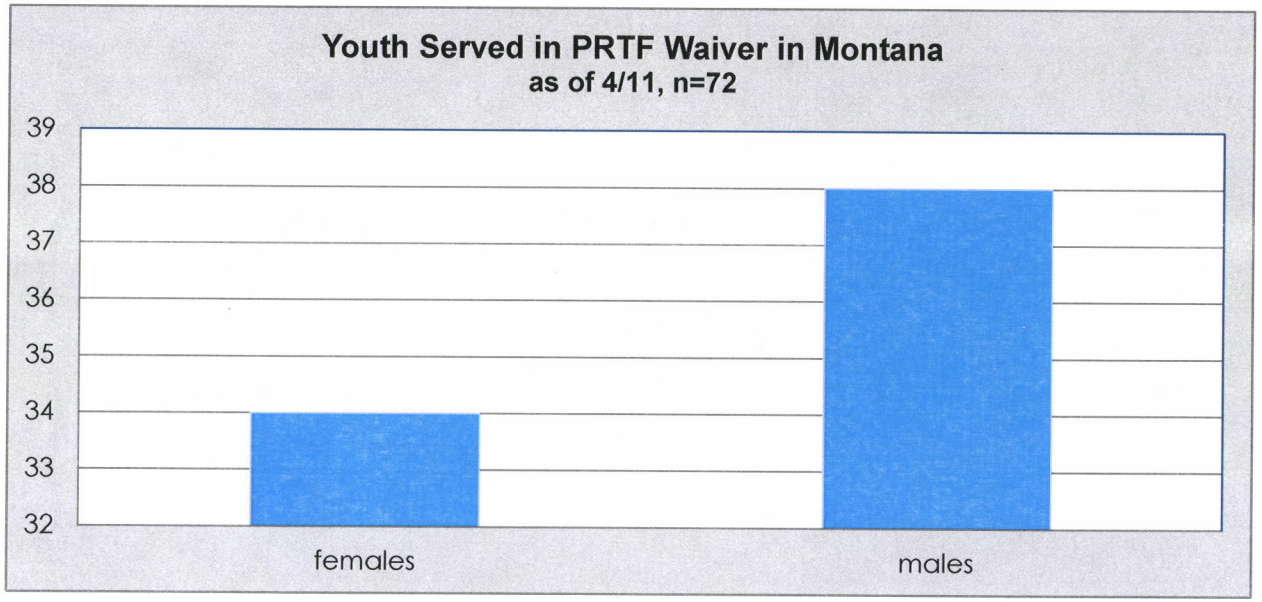
**Request from Senator Webb: Provide PL 10201 and breakout i Home from caseload projection**

Document attached

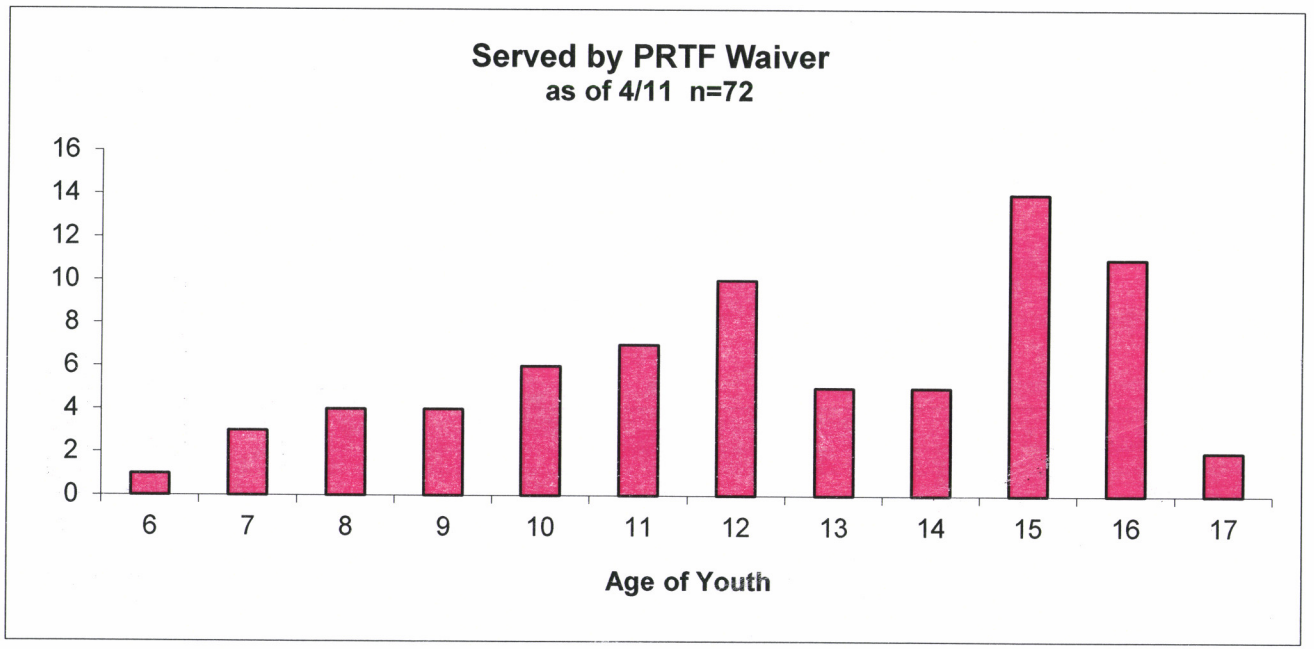
**Request from Representative Ehli: Please update the Vacant FTE list.**

An updated vacant FTE list for the Developmental Services Division has been attached. Of the 27.19 vacant positions listed, 8 positions have been filled, 5 positions are in the screening process and 4 positions are in the recruiting process. The majority of the Division's vacant positions are at the Montana Developmental Center.

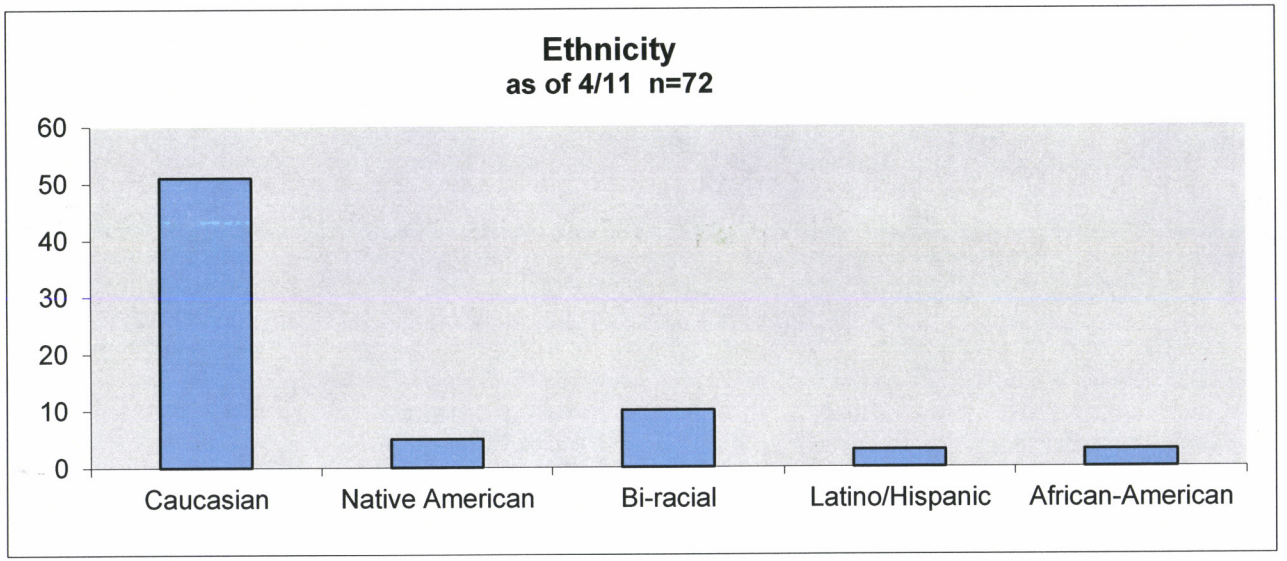
| | |
|---|---|
| females | 34 |
| males | 38 |



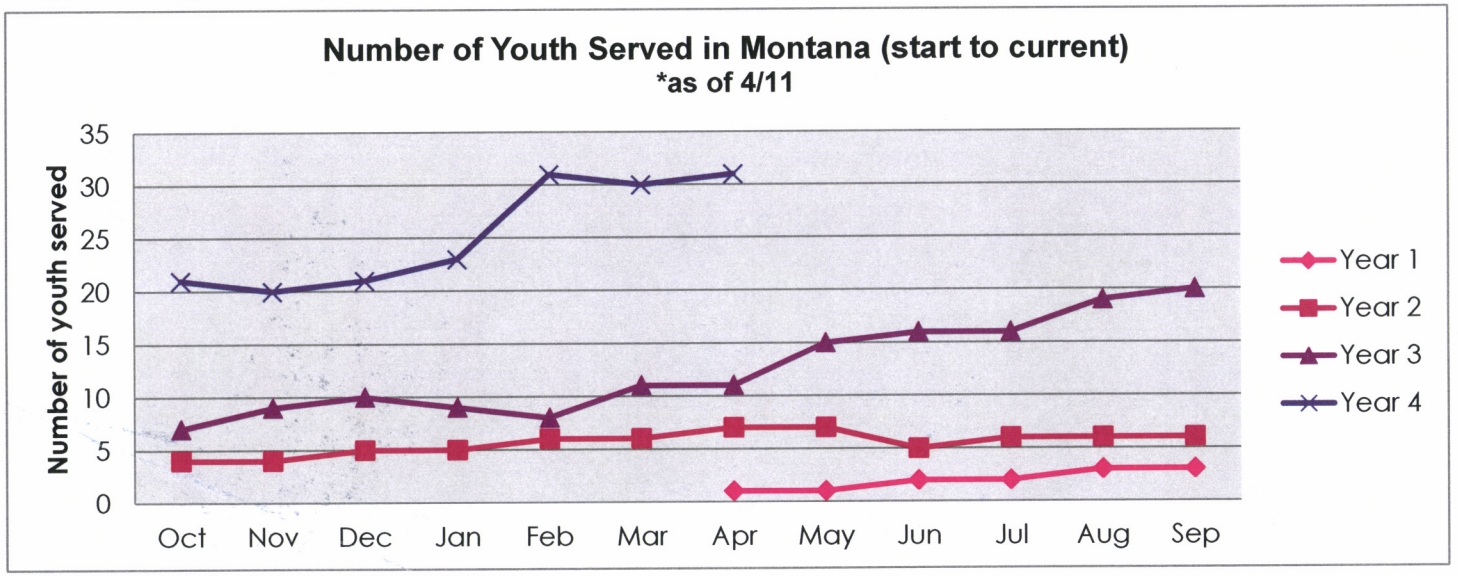

| | |
|---|---|
| 6 | 1 |
| 7 | 3 |
| 8 | 4 |
| 9 | 4 |
| 10 | 6 |
| 11 | 7 |
| 12 | 10 |
| 13 | 5 |
| 14 | 5 |
| 15 | 14 |
| 16 | 11 |
| 17 | 2 |



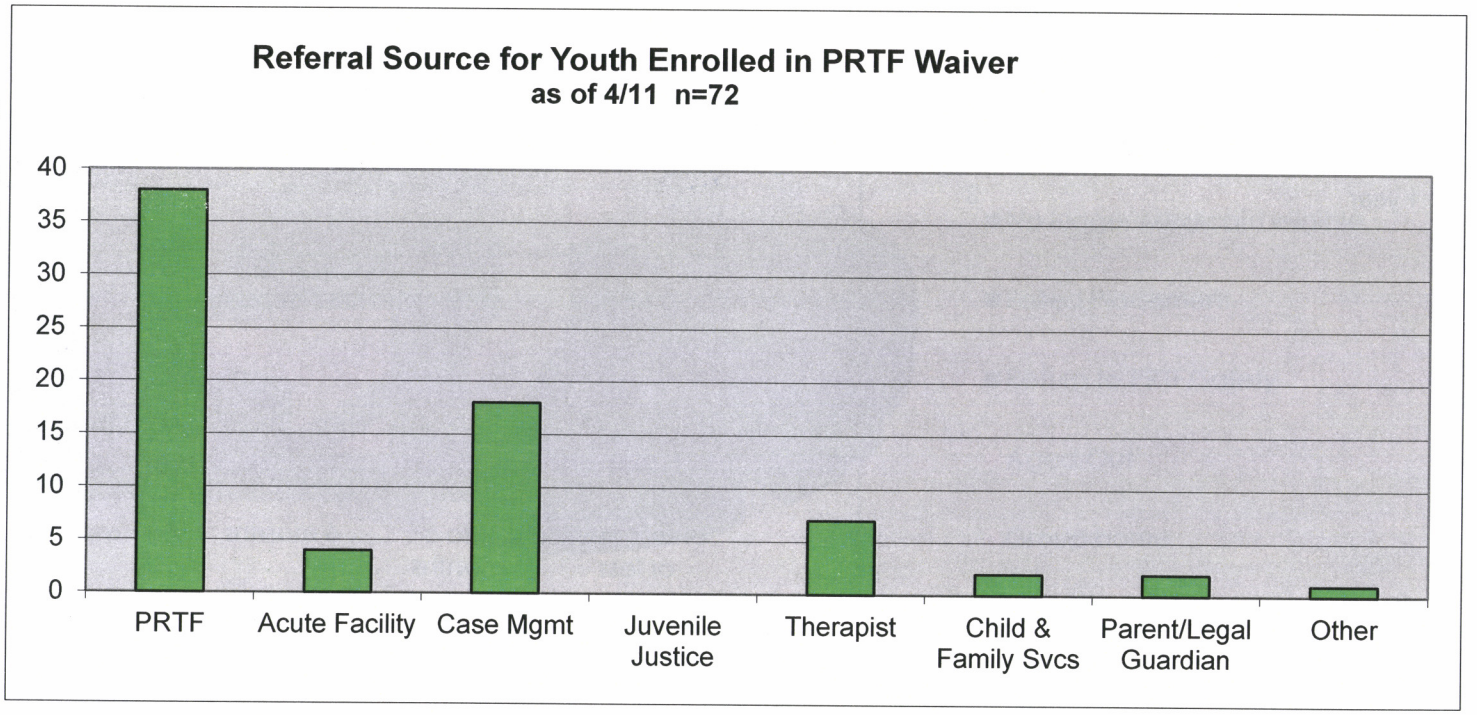
| | |
|---|---|
| Caucasian | 51 |
| Native American | 5 |
| Bi-racial | 10 |
| Latino/Hispanic | 3 |
| African-American | 3 |



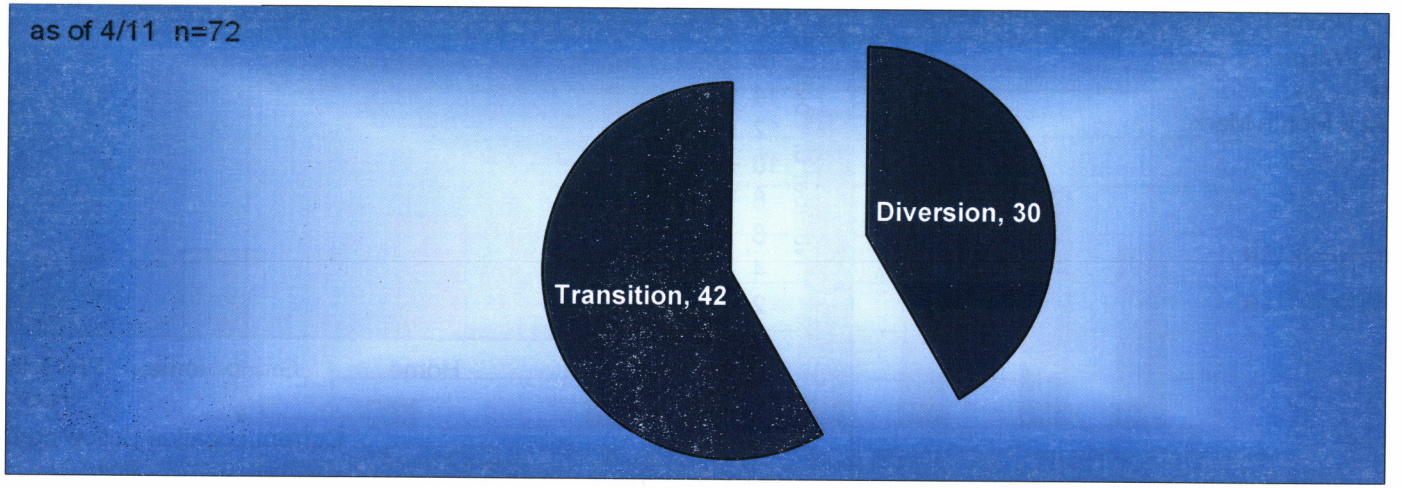

| | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Year 1 | | | | | | | 1 | 1 | 2 | 2 | 3 | 3 |
| Year 2 | 4 | 4 | 5 | 5 | 6 | 6 | 7 | 7 | 5 | 6 | 6 | 6 |
| Year 3 | 7 | 9 | 10 | 9 | 8 | 11 | 11 | 15 | 16 | 16 | 19 | 20 |
| Year 4 | 21 | 20 | 21 | 23 | 31 | 30 | 31 | | | | | |



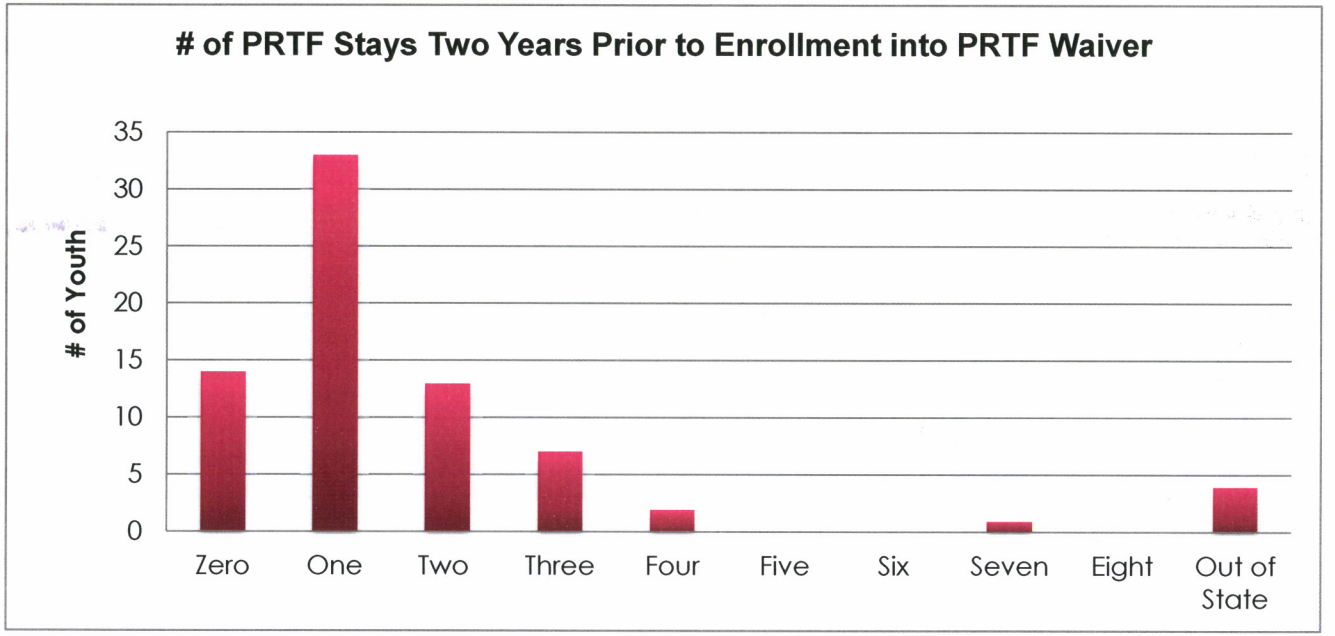
| | |
|---|---|
| PRTF | 38 |
| Acute Facility | 4 |
| Case Mgmt | 18 |
| Juvenile Justice | 0 |
| Therapist | 7 |
| Child & Family Svcs | 2 |
| Parent/Legal Guardian | 2 |
| Other | 1 |



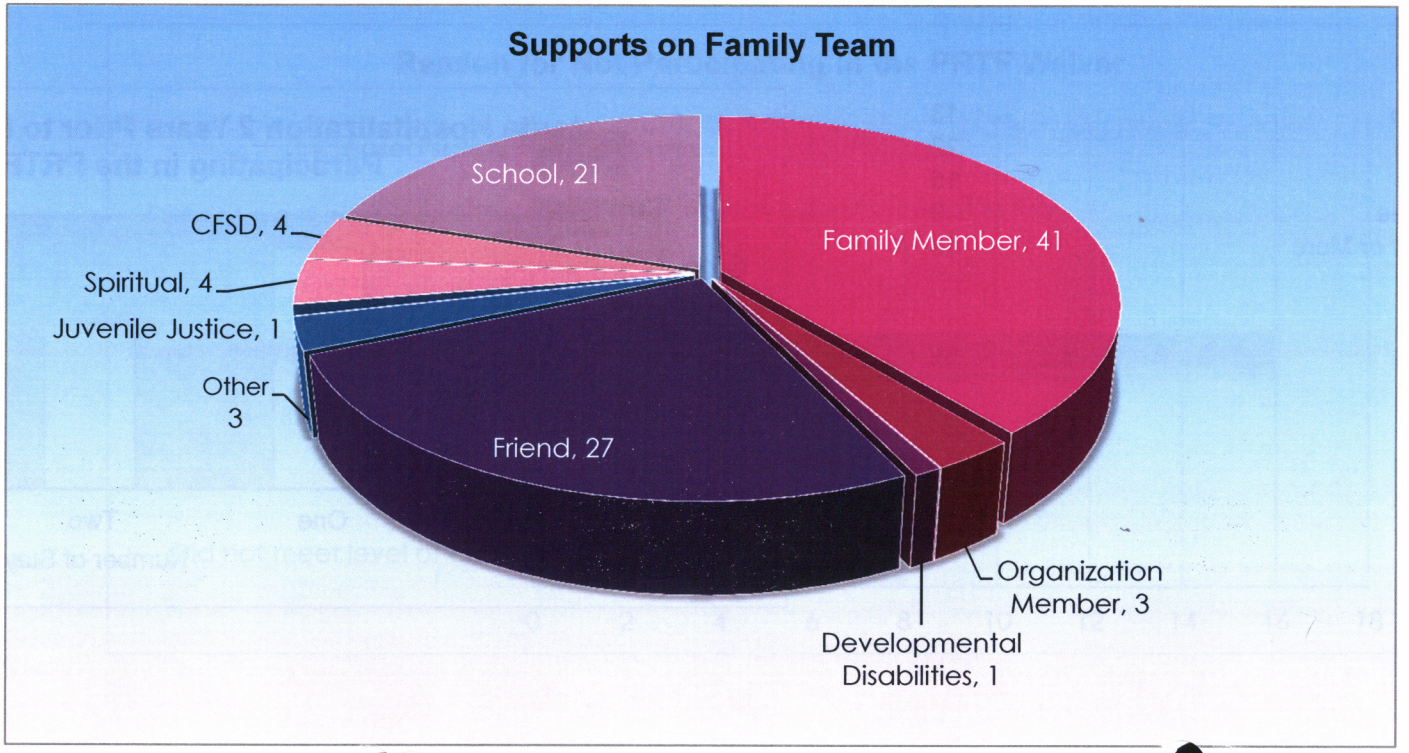

| | |
|---|---|
| Diversion | 30 |
| Transition | 42 |



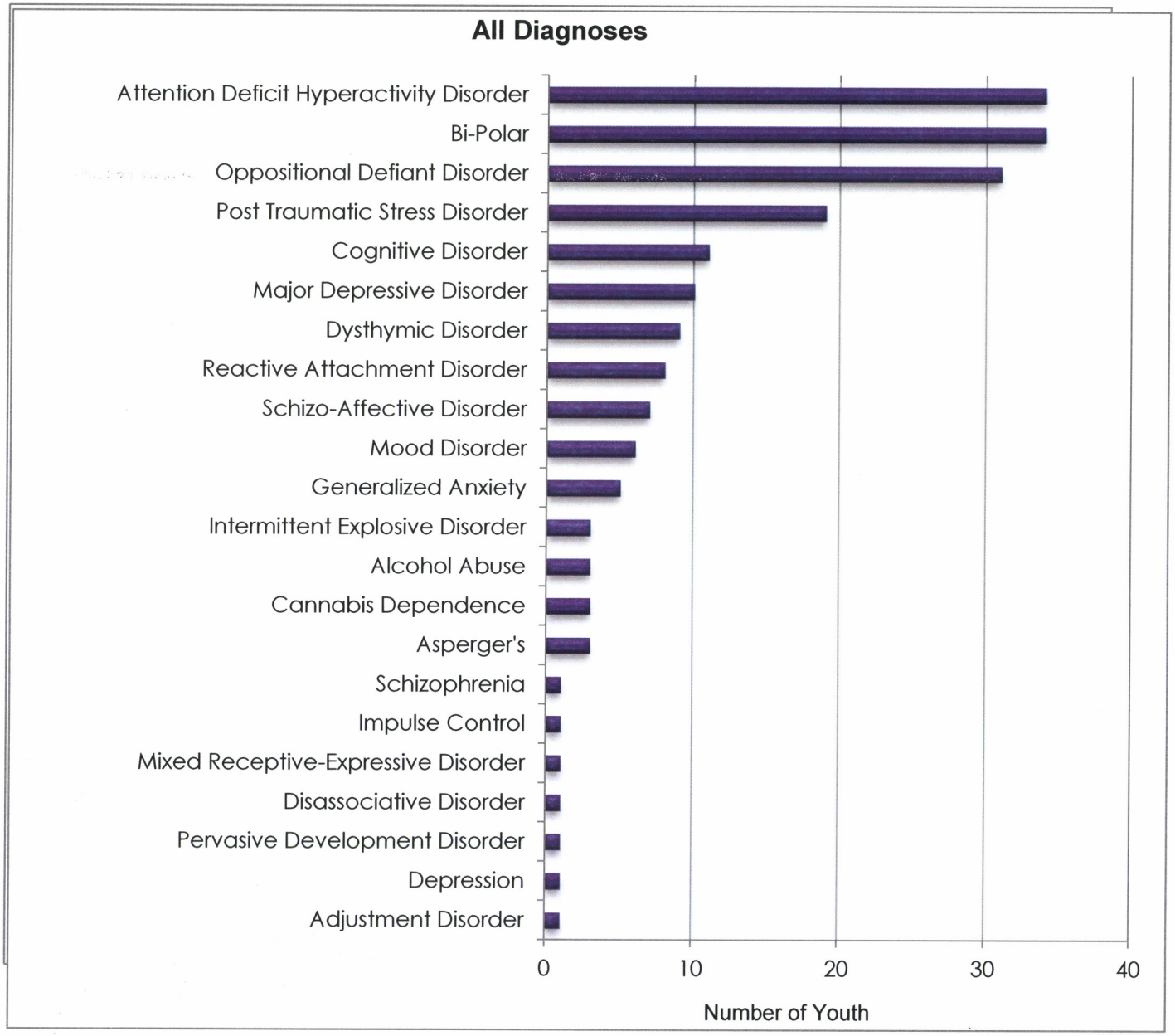
| | |
|---|---|
| Zero | 14 |
| One | 33 |
| Two | 13 |
| Three | 7 |
| Four | 2 |
| Five | 0 |
| Six | 0 |
| Seven | 1 |
| Eight | 0 |
| Out of State | 4 |



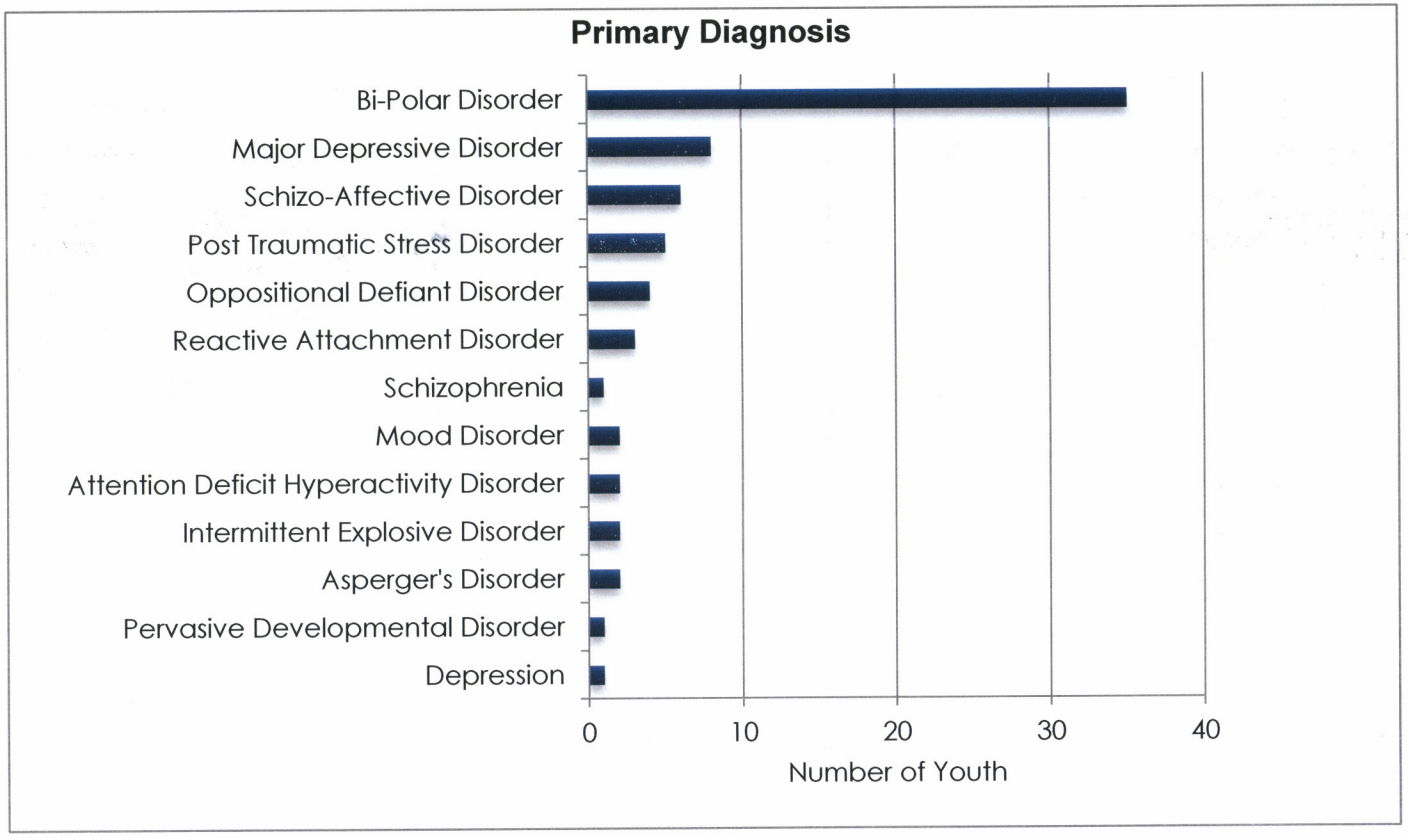

| | |
|---|---|
| Family Member | 41 |
| Organization Member | 3 |
| Developmental Disabilities | 1 |
| Friend | 27 |
| Other | 3 |
| Juvenile Justice | 1 |
| Spiritual | 4 |
| CFSD | 4 |
| School | 21 |



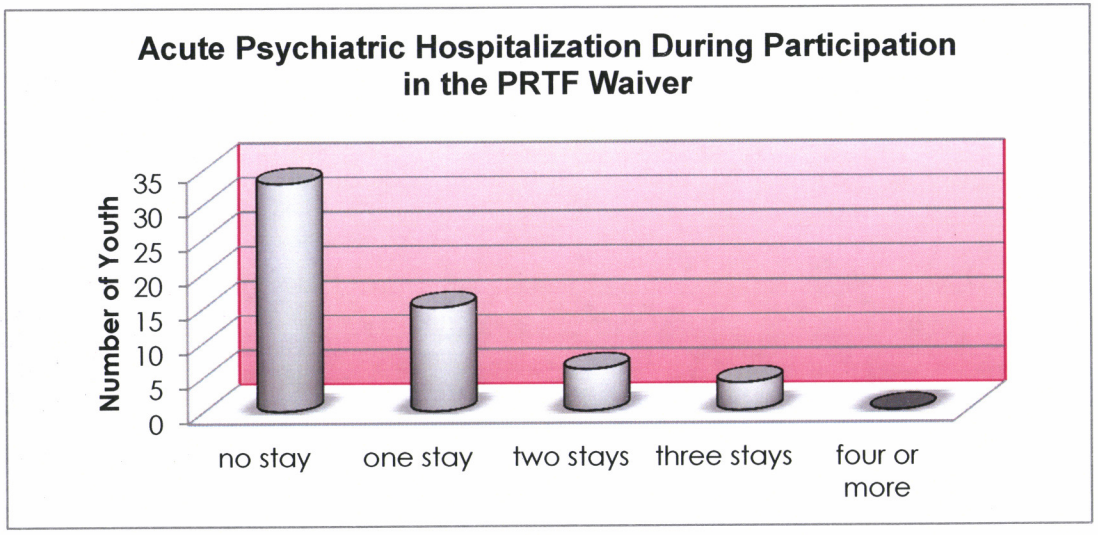
| | |
|---|---|
| Adjustment Disorder | 1 |
| Depression | 1 |
| Pervasive Development Disorder | 1 |
| Disassociative Disorder | 1 |
| Mixed Receptive-Expressive Disor | 1 |
| Impulse Control | 1 |
| Schizophrenia | 1 |
| Asperger's | 3 |
| Cannabis Dependence | 3 |
| Alcohol Abuse | 3 |
| Intermittent Explosive Disorder | 3 |
| Generalized Anxiety | 5 |
| Mood Disorder | 6 |
| Schizo-Affective Disorder | 7 |
| Reactive Attachment Disorder | 8 |
| Dysthymic Disorder | 9 |
| Major Depressive Disorder | 10 |
| Cognitive Disorder | 11 |
| Post Traumatic Stress Disorder | 19 |
| Oppositional Defiant Disorder | 31 |
| Bi-Polar | 34 |
| Attention Deficit Hyperactivity Diso | 34 |



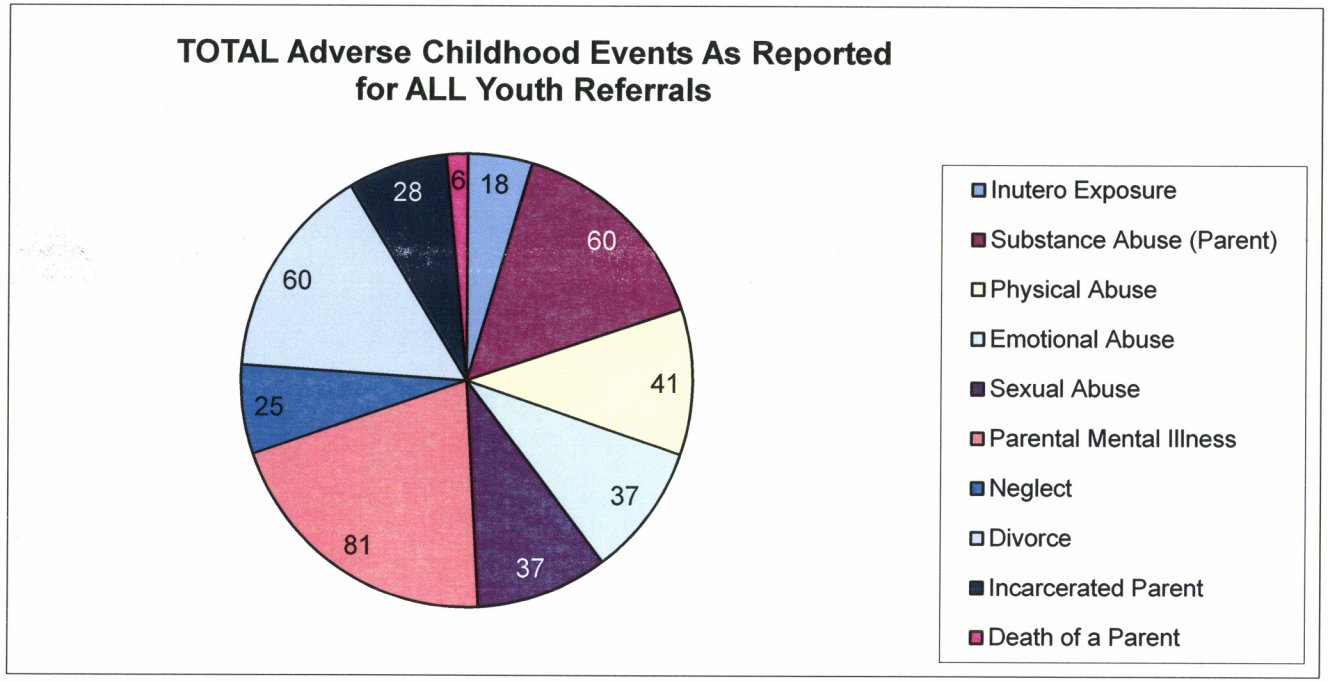
| | |
|---|---|
| Depression | 1 |
| Pervasive Developmental Disorder | 1 |
| Asperger's Disorder | 2 |
| Intermittent Explosive Disorder | 2 |
| Attention Deficit Hyperactivity Diso | 2 |
| Mood Disorder | 2 |
| Schizophrenia | 1 |
| Reactive Attachment Disorder | 3 |
| Oppositional Defiant Disorder | 4 |
| Post Traumatic Stress Disorder | 5 |
| Schizo-Affective Disorder | 6 |
| Major Depressive Disorder | 8 |
| Bi-Polar Disorder | 35 |



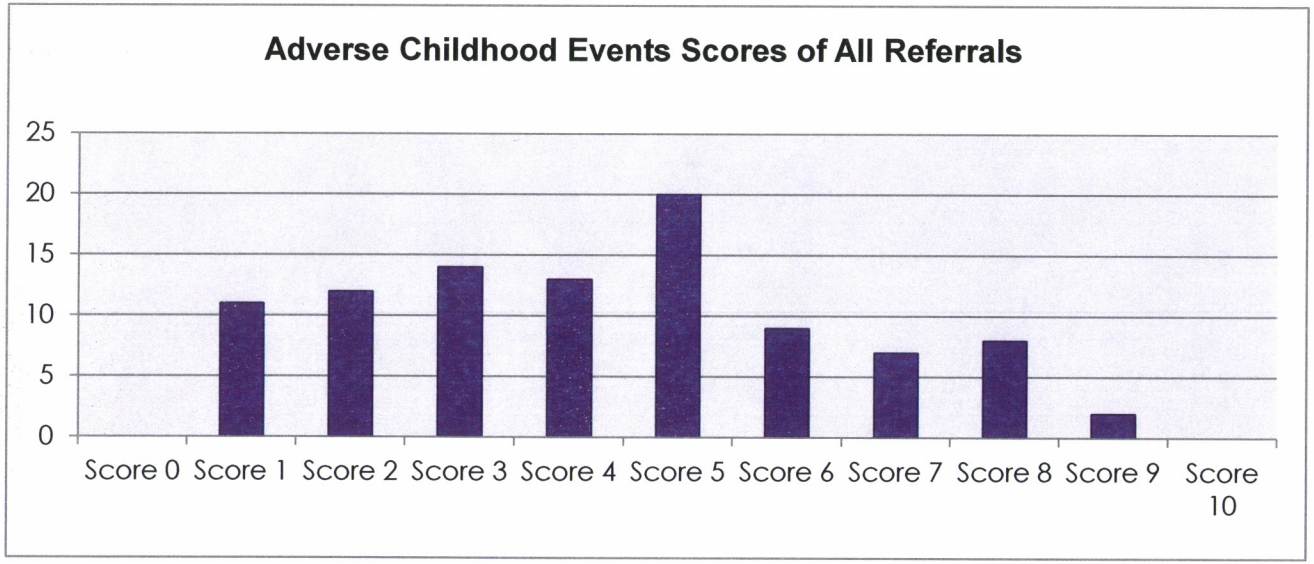

| | |
|---|---|
| no stay | 33 |
| one stay | 15 |
| two stays | 6 |
| three stays | 4 |
| four or more | 0 |



| | |
|---|---|
| Inutero Exposure | 18 |
| Substance Abuse (Parent) | 60 |
| Physical Abuse | 41 |
| Emotional Abuse | 37 |
| Sexual Abuse | 37 |
| Parental Mental Illness | 81 |
| Neglect | 25 |
| Divorce | 60 |
| Incarcerated Parent | 28 |
| Death of a Parent | 6 |




| | |
|---|---|
| Score 0 | 0 |
| Score 1 | 11 |
| Score 2 | 12 |
| Score 3 | 14 |
| Score 4 | 13 |
| Score 5 | 20 |
| Score 6 | 9 |
| Score 7 | 7 |
| Score 8 | 8 |
| Score 9 | 2 |
| Score 10 | 0 |



## CANS: *Information Integration and Communication*

CANS is designed as a practice framework for communicating about a shared vision and using information as an integrated story to inform planning, support decisions, and monitor outcomes. It provides a common language for multidisciplinary settings for consensus building, and it is action-oriented and focused on both the planning process and outcomes.

### *Guiding Principles*

1. Each CANS item is included because each one may impact service planning.
2. Item rating levels translate immediately into action.
3. Focus on the child's needs, not interventions that could mask a need.
4. Consider development and culture before translating into action levels.
5. It is about the 'what,' not about the 'why.'
6. Use a 30-day window for rating to keep the assessment current and meaningful.

**REMINDER: Before rating, be sure to consider the following factors.**

- *Do you have evidence of a need or strength?*
- *What current services are already in place?*
- *Is it impacting the child/youth's functioning? If so, how severely?*
- *Respect and consider the child or family's culture – Culture is broadly defined from the experience of the individuals, family, and group.*
- *What are some typical developmental needs or behaviors?*
- *Stay focused on the 'what,' not the 'why.'*

### CANS Ratings: *Action Levels*

The way the CANS works is that each item suggests different pathways for service or treatment planning. There are four levels of each item with anchored definitions; however, these definitions are designed to translate into the following action levels (separate for needs and strengths).

***THE MAJORITY OF ITEMS ON THE CANS SHOULD BE RATED IN THE CONTEXT OF WHAT IS NORMATIVE FOR A CHILD'S OR YOUTH'S AGE/DEVELOPMENTAL STAGE.***

| For Needs Domains | | For Strengths Domain | |
|---|---|---|---|
| 0 | No evidence of a need / no need for action | 0 | Centerpiece strength of treatment planning |
| 1 | Watchful waiting / prevention / mild need | 1 | Useful strength in treatment planning |
| 2 | Action needed / moderate need | 2 | Strength has been identified in this area but needs more development to be useful in treatment planning |
| 3 | Immediate / Intensive action / severe need | 3 | No strength is identified in this area or there is no information |

### *Montana iHome CANS Policy*

- CANS will be initiated within 14 calendar days of enrollment/start of care.
- CANS will be finalized within 30-days of enrollment.
- CANS will be updated a minimum of every 90 days from the completion of the last CANS.
- CANS is required upon discharge.

Youth Name: _____ Date: _____

*For use with MJ Henry & Associates, Inc. customized version of Montana CANS Comprehensive Reference Guide*

**Key for Traumatic/Adverse Childhood Experiences Domain:**

0 = No evidence of any trauma of this type.
1 = A single incident or suspicion of this trauma or ACE.
2 = Child has experienced multiple incidents or moderate degree of this trauma or ACE.
3 = Child experienced repeated and severe incidents of trauma or ACE.

## Traumatic/Adverse Childhood Experiences Domain

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 1. Sexual Abuse | ○ | ○ | ○ | ○ | |
| 2. Physical Abuse | ○ | ○ | ○ | ○ | |
| 3. Emotional Abuse | ○ | ○ | ○ | ○ | |
| 4. Neglect | ○ | ○ | ○ | ○ | |
| 5. Medical Trauma | ○ | ○ | ○ | ○ | |
| 6. Family Violence | ○ | ○ | ○ | ○ | |
| 7. Community Violence | ○ | ○ | ○ | ○ | |

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 8. School Violence | ○ | ○ | ○ | ○ | |
| 9. Natural/Manmade Disasters | ○ | ○ | ○ | ○ | |
| 10. War Affected | ○ | ○ | ○ | ○ | |
| 11. Terrorism Affected | ○ | ○ | ○ | ○ | |
| 12. Witness to Criminal Activity | ○ | ○ | ○ | ○ | |
| 13. Parental Criminal Behavior | ○ | ○ | ○ | ○ | |
| 14. Disruption in Caregiving | ○ | ○ | ○ | ○ | |

***COMMENTS:***

**Key for Child Strengths Domain:**

0 = Centerpiece strength
1 = Useful strength
2 = Identified strength
3 = Not yet identified strength / No information about a strength in this area

## Child Strengths Domain

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 15. Family | ○ | ○ | ○ | ○ | |
| 16. Interpersonal | ○ | ○ | ○ | ○ | |
| 17. Educational | ○ | ○ | ○ | ○ | ○ |
| 18. Vocational | ○ | ○ | ○ | ○ | ○ |
| 19. Coping/Savoring Skills | ○ | ○ | ○ | ○ | |
| 20. Optimism | ○ | ○ | ○ | ○ | |
| 21. Talents/Interests | ○ | ○ | ○ | ○ | |

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 22. Spiritual/Religious | ○ | ○ | ○ | ○ | |
| 23. Community Life | ○ | ○ | ○ | ○ | |
| 24. Relationship Permanence | ○ | ○ | ○ | ○ | |
| 25. Resilience | ○ | ○ | ○ | ○ | |
| 26. Youth Involvement | ○ | ○ | ○ | ○ | |
| 27. Use of Free Time | ○ | ○ | ○ | ○ | |
| 28. Peer Influences | ○ | ○ | ○ | ○ | |

***COMMENTS:***

**Key for Other Domains:**

0 = No evidence or no reason to believe that the rated item requires any action.
1 = A need for watchful waiting, monitoring, or possibly preventive action.
2 = A need for action. Some strategy is needed to address the problem/need.
3 = A need for immediate or intensive action. This level indicates an immediate safety concern or a priority for intervention.

## *Life Functioning Domain*

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 29. Family | ○ | ○ | ○ | ○ | |
| 30. Living Situation | ○ | ○ | ○ | ○ | |
| 31. Social Functioning | ○ | ○ | ○ | ○ | |
| 32. Developmental/Intellectual | ○ | ○ | ○ | ○ | ○ |
| 33. Recreational | ○ | ○ | ○ | ○ | |
| 34. Legal | ○ | ○ | ○ | ○ | |
| 35. Medical | ○ | ○ | ○ | ○ | |

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 36. Physical | ○ | ○ | ○ | ○ | |
| 37. Sleep | ○ | ○ | ○ | ○ | |
| 38. Sexual Development | ○ | ○ | ○ | ○ | |
| 39. Activities in Daily Living | ○ | ○ | ○ | ○ | |
| 40. School Behavior | ○ | ○ | ○ | ○ | ○ |
| 41. School Achievement | ○ | ○ | ○ | ○ | ○ |
| 42. School Attendance | ○ | ○ | ○ | ○ | ○ |

***COMMENTS:***

## *Cultural Considerations Domain*

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 43. Language | ○ | ○ | ○ | ○ | |
| 44. Identity | ○ | ○ | ○ | ○ | |
| 45. Ritual | ○ | ○ | ○ | ○ | |
| 46. Culture Stress | ○ | ○ | ○ | ○ | |

***COMMENTS:***

## Child Behavioral/Emotional Needs Domain

| | 0 | 1 | 2 | 3 | N/A | | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] Adjustment to Trauma | ○ | ○ | ○ | ○ | | 55. Conduct | ○ | ○ | ○ | ○ | |
| [redacted] Emot/Phys Regulation | ○ | ○ | ○ | ○ | | 56. Substance Abuse | ○ | ○ | ○ | ○ | |
| 49. Psychosis | ○ | ○ | ○ | ○ | | 57. Attachment Difficulties | ○ | ○ | ○ | ○ | |
| 50. Attention/Concentration | ○ | ○ | ○ | ○ | | 58. Eating Disturbances | ○ | ○ | ○ | ○ | |
| 51. Impulsivity | ○ | ○ | ○ | ○ | | 59. Behavioral Regressions | ○ | ○ | ○ | ○ | |
| 52. Depression | ○ | ○ | ○ | ○ | | 60. Somatization | ○ | ○ | ○ | ○ | |
| 53. Anxiety | ○ | ○ | ○ | ○ | | 61. Anger Control | ○ | ○ | ○ | ○ | |
| 54. Oppositional Behavior | ○ | ○ | ○ | ○ | | 62. Mood Disturbance | ○ | ○ | ○ | ○ | |

***COMMENTS:***

## Child Risk Behaviors Domain

| | 0 | 1 | 2 | 3 | N/A | | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] Suicide Watch | ○ | ○ | ○ | ○ | | 69. Delinquency | ○ | ○ | ○ | ○ | |
| 64. Self-Mutilation | ○ | ○ | ○ | ○ | | 70. Judgment | ○ | ○ | ○ | ○ | |
| 65. Other Self-Harm | ○ | ○ | ○ | ○ | | 71. Fire-Setting | ○ | ○ | ○ | ○ | |
| 66. Danger to Others | ○ | ○ | ○ | ○ | | 72. Intentional Misbehavior | ○ | ○ | ○ | ○ | |
| 67. Sexual Aggression | ○ | ○ | ○ | ○ | | 73. Sexually-Reactive Behaviors | ○ | ○ | ○ | ○ | |
| 68. Runaway | ○ | ○ | ○ | ○ | | 74. Bullying | ○ | ○ | ○ | ○ | |

***COMMENTS:***

[redacted]

## *Rating of Children Five Years Old and Younger*

***The following items are required for any child who is five years old or younger or developmentally disabled (DD); however, they may be rated for any child/youth if they represent a need for a specific youth.***

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 75. Motor | ○ | ○ | ○ | ○ | ○ |
| 76. Sensory | ○ | ○ | ○ | ○ | ○ |
| 77. Communication | ○ | ○ | ○ | ○ | ○ |
| 78. Failure to Thrive | ○ | ○ | ○ | ○ | ○ |
| 79. Feeding/Elimination | ○ | ○ | ○ | ○ | ○ |
| 80. Birth Weight | ○ | ○ | ○ | ○ | ○ |
| 81. Prenatal Care | ○ | ○ | ○ | ○ | ○ |

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 82. Substance Exposure | ○ | ○ | ○ | ○ | ○ |
| 83. Labor and Delivery | ○ | ○ | ○ | ○ | ○ |
| 84. Parent or Sibling Problems | ○ | ○ | ○ | ○ | ○ |
| 85. Maternal Availability | ○ | ○ | ○ | ○ | ○ |
| 86. Curiosity | ○ | ○ | ○ | ○ | ○ |
| 87. Playfulness | ○ | ○ | ○ | ○ | ○ |
| 88. Temperament | ○ | ○ | ○ | ○ | ○ |
| 89. Day Care/Preschool | ○ | ○ | ○ | ○ | ○ |

***COMMENTS:***

## *Transition to Adulthood Domain*

***The following items are required for youth 14 years, 6 months and older. However, any of these items can be rated regardless of age if they represent a need for a specific individual.***

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 90. Independent Living Skills | ○ | ○ | ○ | ○ | ○ |
| 91. Transportation | ○ | ○ | ○ | ○ | ○ |
| 92. Parenting Roles | ○ | ○ | ○ | ○ | ○ |
| 93. Intimate Relationships | ○ | ○ | ○ | ○ | ○ |

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 94. Medical Compliance | ○ | ○ | ○ | ○ | ○ |
| 95. Educational Attainment | ○ | ○ | ○ | ○ | ○ |
| 96. Victimization | ○ | ○ | ○ | ○ | ○ |
| 97. Job Functioning | ○ | ○ | ○ | ○ | ○ |
| 98. Transition to Adult Services | ○ | ○ | ○ | ○ | ○ |

***COMMENTS:***

## *Caregiver Resources and Needs Domain*

**PLEASE NOTE:** ***Rate the caregiver who has the highest needs and may impact child's functioning negatively.***

TITLE/ROLE of CAREGIVER #1 (Relationship to Child): _____

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 99. Physical Health | ○ | ○ | ○ | ○ | |
| 100. Mental Health | ○ | ○ | ○ | ○ | |
| 101. Substance Use | ○ | ○ | ○ | ○ | |
| 102. Developmental | ○ | ○ | ○ | ○ | |
| 103. Supervision | ○ | ○ | ○ | ○ | |
| 104. Involvement with Care | ○ | ○ | ○ | ○ | |
| 105. Knowledge | ○ | ○ | ○ | ○ | |
| 106. Organization | ○ | ○ | ○ | ○ | |

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 107. Social Resources | ○ | ○ | ○ | ○ | |
| 108. Residential Stability | ○ | ○ | ○ | ○ | |
| 109. Safety | ○ | ○ | ○ | ○ | |
| 110. Marital/Partner Violence | ○ | ○ | ○ | ○ | |
| 111. Post-Traumatic Reactions | ○ | ○ | ○ | ○ | |
| 112. Financial Resources | ○ | ○ | ○ | ○ | |
| 113. Family Stress | ○ | ○ | ○ | ○ | |
| 114. Accessibility to Child Care | ○ | ○ | ○ | ○ | |
| 115. Transportation | ○ | ○ | ○ | ○ | |

TITLE/ROLE of CAREGIVER #1 (Relationship to Child): _____

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| [redacted]Physical Health | ○ | ○ | ○ | ○ | |
| [redacted]Mental Health | ○ | ○ | ○ | ○ | |
| 101. Substance Use | ○ | ○ | ○ | ○ | |
| 102. Developmental | ○ | ○ | ○ | ○ | |
| 103. Supervision | ○ | ○ | ○ | ○ | |
| 104. Involvement with Care | ○ | ○ | ○ | ○ | |
| 105. Knowledge | ○ | ○ | ○ | ○ | |
| 106. Organization | ○ | ○ | ○ | ○ | |

| | 0 | 1 | 2 | 3 | N/A |
|---|---|---|---|---|---|
| 107. Social Resources | ○ | ○ | ○ | ○ | |
| 108. Residential Stability | ○ | ○ | ○ | ○ | |
| 109. Safety | ○ | ○ | ○ | ○ | |
| 110. Marital/Partner Violence | ○ | ○ | ○ | ○ | |
| 111. Post-Traumatic Reactions | ○ | ○ | ○ | ○ | |
| 112. Financial Resources | ○ | ○ | ○ | ○ | |
| 113. Family Stress | ○ | ○ | ○ | ○ | |
| 114. Accessibility to Child Care | ○ | ○ | ○ | ○ | |
| 115. Transportation | ○ | ○ | ○ | ○ | |

***COMMENTS:***

Certified CANS Assessor Name: _____

[redacted]ignature _____

# Montana Developmental Center Boulder

November 1 & 2

# 2012

A Site Review Report with Recommendations of the Treatment Services Provided at Montana Developmental Center, Boulder.

Mental Disabilities Board of Visitors

## Contents

# OVERVIEW

**Residential Facility reviewed**:

Montana Developmental Center
Boulder, Montana

Gene Haire, Superintendent

**Authority for review:**

Montana Code Annotated, 53-20-104

**Purpose of review**:

1) To learn about services provided at Montana Developmental Center
2) To assess the degree to which the services provided are humane, consistent with professional standards, and incorporate Board of Visitors standards for residential facility services.
3) To review the files of individuals served to assure that Individual Treatment Plans are in place and are being implemented
4) To make recommendations for improvement of services.
5) To report to the Governor regarding the status of services.

**BOV review team**:

**Board:**
Brodie Moll, Board Chair
Lin Olson, Board Member

**Consultants**:
Jennifer Elison, Ed.D, RN, LCPC
Adele Furby, LCPC
Irene Walters, APRN

**Staff**:
Alicia Pichette
Craig Fitch
Lisa Swanson

**Review process**:

- Interview MDC staff – management, clinical, program, supervisor and direct care
- Observe Treatment Activities
- Tour Residential Units and Assessment & Stabilization Unit
- Inspect Physical Plant/Campus
- Review Policy and Procedures
- Examine Training/Certification for Staff
- Review Individual Treatment Plans
- Tour the Medical Clinic and Examine Medical Records

# QUESTIONS - STANDARDS

## Organizational Planning and Quality Improvement

### *Organizational Planning:*

Strengths/Observations:
Since the 2010 Mental Disabilities Board of Visitors (BOV) site review, the Montana Developmental Center (MDC) has restructured its mission, vision, and purpose to address the evolving needs of the individuals served. MDC has developed a strategic plan based on recommendations provided in the 2010 site review report. The recommendations were translated into a work plan/implementation/timeline document that created the foundation for comprehensive restructuring to focus on treatment services provided at MDC.

Action steps for implementing the goals established in the timeline include defining individual and team responsibilities and completing tasks by set dates. Position descriptions are being written to include required competencies that connect staff knowledge and skills with the treatment needs of the individuals served.

MDC's framework for change focuses on treatment and staff training to achieve its goals. The site review team reflected that although the process to create a framework for transforming the service delivery system at MDC did not specifically use a collaborative process to include all interested parties at the outset, it may have been the best, if not the only strategy possible under the circumstances.

MDC created an Organizational Chart this year to reflect the updated mission and purpose of the facility. The chart identifies the leadership and management structure for the facility, denotes supervisory roles for each service division, and provides clarity for the staff about the organizational structure of MDC.

Suggestions:
Develop a communication structure to provide both formal and informal opportunities for staff, individuals served and their family members/guardians, and other interested parties to provide ideas, goals and comments for a strategic planning concept that is dynamic and inclusive.

### *Quality Improvement:*

Strengths/Observations:
MDC has taken Organizational Planning and Quality Improvement to the administrative level incorporating a specific quality mission statement and adopting a management plan to guide the facility's transformation efforts. Facility leadership has established quality as a standard expectation for the facility and staff.

To establish a formal quality improvement process, a Quality Assurance Program position was created and a Quality Management Director (QMD) has been hired. The individual in this position is responsible to develop a continuous quality improvement process for MDC that will analyze data collected from all departments on campus; evaluate the data and establish quality improvement strategies to improve services. The foundation for the quality improvement process includes vision and mission statements and a Quality Management Plan. The plan sets goals for educating core staff in each discipline about the quality management process, and expectations for staff to adhere to the quality management plan within their discipline. The plan sets specific assignments for staff and establishes timeframes for achieving goals; some of which appear to have been met at the time of the site review. As a component of the continuous quality improvement efforts, incident reports are reviewed to determine if treatment interventions or staff training would have prevented the incident or changed the outcome of the incident.

The medical unit has a quality assurance practice in place for monitoring laboratory tests, EKG's and routine medical care such as dental services. Medication errors are reviewed and analyzed by the Director of Nursing. When system problems are identified they are addressed by following quality assurance procedures.

Data and incident reports filed electronically daily on the THERAP®[1] System provide treatment team members information to evaluate and address treatment and safety for individuals served. Staff (direct care, clinical, medical and up to the Superintendent) can review reports, compare treatment data notes with treatment plans for goals achievement, evaluate incidents for quality assurance purposes and develop interventions to address treatment and safety for individuals served.

Quality Assurance is a standing agenda item for leadership and staff team meetings and quality improvement is part of the daily culture of the facility.

Suggestions:
Consistently communicate with staff about the quality assurance measures that will occur as a result of the data collection/analysis process.

Update policy and procedure documents to correct the name of the treatment plan from Personal Service Plan (PSP) to Individual Treatment Plan (ITP).

## Rights, Responsibilities, and Safety

### *Rights, Responsibilities*:

Strengths/Observations:
The Handbook for People Receiving Services on the Assessment and Stabilization Unit (ASU) defines rights and responsibilities for the individuals served at MDC. According to the General Admissions Procedure, the social worker organizes the intake process and is responsible for completing a Notification of Explanation of Rights for all persons being admitted to the MDC. Individuals served and family members/guardians verify that their rights and responsibilities have been presented and explained to them by signing a verification form. A handbook of rights and responsibilities specific to Units One through Six is currently being drafted.

The General Admissions Procedure provides information about the complaint and grievance procedures and is presented to clients and family members/guardians by the social worker during admission/intake. Contact information for advocacy services provided by BOV and Disability Rights Montana (DRM) is listed in the Handbook for People Receiving Services on the Assessment and Stabilization Unit (ASU). At admission, the social worker offers information about the BOV to individuals served and their family members/guardians.

The THERAP® System provides a platform for secure communications between families and MDC staff that has improved the grievance process for individuals served and their family members/guardians. When asked, individuals residing at MDC replied that they are aware of their rights and the process for contacting advocacy services.

Suggestions:
Assure informational posters describing the role of and access to the BOV and DRM, including a statement about the requirements of 53-20-163, MCA, are posted in each of the units and are readily visible on campus.

As individuals move between the Intermediate Care Facility for the Mentally Retarded (ICF/MR) and the Intermediate Care Facility for the Developmentally Disabled (ICF/DD), assure that the facility informs family members/guardians if rights and responsibilities differ between the two areas on campus and asks family members/guardians to sign an updated Notification of Explanation of Rights form.

### *Safety*:

Strengths/Observations:
MDC has done a good job since 2010 of updating policies and procedures for reporting, investigating and addressing reported abuse and/or neglect. The policies and procedures reviewed now include a comprehensive set of definitions, investigative procedures and reporting requirements, including a step by

[1] THERAP Services, LLC
http://www.therapservices.net/

step investigation procedure log which guides the investigator through the process. In addition, potential antecedents to incidents are reviewed in the investigatory process and when appropriate, a clinical opinion is included in the investigation. As part of the investigation process, the QMD reviews the events and actions that preceded the incident; determines how such events could have been prevented; and what, if anything, staff should have done differently. Clinical oversight is part of the process for investigating critical incidents and ensures that individuals served are supported during investigations. The use of contracted 'on-call investigators' ended in 2011. MDC has not completed the work of defining 'conflict of interest' in policies/procedures with regard to investigating allegations of abuse/neglect.

The facility has established a schedule for staff training about legal and civil rights of individuals served which includes requirements for reporting and investigating allegations of abuse/neglect. All staff interviewed appeared to be fully aware of the correct procedures for reporting suspected abuse/neglect. In-service training occurs as policies and procedures are introduced or updated. Overall, MDC is implementing the requirements of Section 53-20-163, MCA, *Abuse and neglect of residents prohibited.*

BOV reviewed individual records, incident reports, and interviewed staff about the QA process following investigation of incidents and observed that MDC is not consistently debriefing staff after a reported incident has been resolved.

Individuals served have access to staff of their own gender and can identify who they consider to be 'preferred staff.' A preferred staff member is often able to assist an individual during stressful situations by prompting them to use their coping skills.

Medical records reviewed contained erroneously filed records.

Suggestions:

Staff and individuals served would benefit from a therapeutic review and discussion of their individual experiences and perspectives after a serious incident has occurred.

Conduct an audit of medical charts for individuals currently being served at MDC to assure that information is filed correctly.

## Client / Family Member Participation

Strengths/Observations:
Family members/guardians are encouraged to be involved in treatment and the social worker is the agency contact person identified for client and family member communication. The Qualified Mental Retardation Professional (QMRP) supervises the social worker and will also contact family members/guardians as needed. BOV has received complaints from family members/guardians of individuals served about the inconsistency of contact from MDC when their family member has experienced an important event.

Nursing staff interviewed reported that family communication regarding medication changes are documented in the psychiatrist's notes and that the social worker documents family communication in the THERAP® System.

The treatment team includes individuals served and family members/guardians (when interested and able to attend) in treatment planning and plan reviews. The QMRP and social worker assist the individuals served in maintaining regular communication with family members/guardians. Individuals served and family members/guardians are routinely provided with copies of the treatment plan. If family members/guardians or individuals express concern about the treatment planning process or disagree with any part of the treatment plan, the QMRP will communicate directly with the family. BOV observed that communication between MDC and family members/guardians of individuals served is inconsistent.

Treatment decisions are based on clinical practices and focused on assisting individuals served to learn the skills to successfully live in a community setting. Planning for discharge begins at or before the time of admission, and individuals are referred for community placement as soon as possible after admission. Active treatment is built into every interaction between staff and individuals served. A full menu of treatment activities is in place and is reviewed continually. A daily schedule of treatment activities is integrated across all disciplines and is consistent. Individual treatment schedules are based on identified treatment needs and

a master treatment schedule. Individuals served participate in scheduled treatment activities daily. Treatment plans have specific, measureable objectives, strategies to achieve objectives, and defined responsibilities and time frames for implementing strategies, with treatment goals continually being updated and revised.

After assessment and diagnosis, the psychiatrist provides education to the client/family related to diagnosis, medications, options for treatment and expected outcomes. The BOV team reviewed treatment plans and charts, and concluded that this education by the psychiatrist is ongoing over the course of an individual's stay at MDC.

Suggestions:
Designate a section in the treatment plan for team members to document their communication with families/guardians.

Evaluate the treatment planning process and survey individuals served and their family members/guardians to determine if they were satisfied with the level of their involvement in the process.

## Cultural Effectiveness

Strengths/Observations:
Staff interviewed reported being aware of the need to address cultural, ethnic, social, historical and spiritual differences that may be relevant to an individual's treatment. MDC has attempted to provide training for staff about these issues and acknowledges the importance of ongoing training on these issues. However, MDC does not have a Cultural Effectiveness Plan in place to direct culturally competency training/issues.

MDC has an Indian Club conducted by recreation program staff, several individuals served attend and all are welcome to attend. Activities include attending cultural events off and on campus. Native American speakers from different tribes have been called upon to provide training for staff about cultural and language differences between tribes. The recreation staff who coordinate the program are not Indian and readily admit the Club would benefit if Native American organizations in the community could bring information about cultural history, language, different traditions and ways of communicating, and their spiritual practices to MDC.

Suggestions:
Develop a pro-active plan for integrating more cultural and spiritual awareness into the MDC culture. This would include:

- Adding a statement regarding multicultural and spiritual awareness in the MDC Vision Statement.
- Requiring all employees of MDC to successfully complete a basic class in multicultural and spiritual awareness.
- Require all employees who come in direct contact with MDC clients to complete at least one class in multicultural awareness annually; emphasize such education for psychiatric aides and shift leaders.
- Add cultural and spiritual assessments to client intake assessments. Enhance efforts to identify each client's cultural and spiritual background, each client's current cultural and spiritual orientation (for example for a Native American, ascertain whether the individual considers himself/herself "traditional" or not), and integrate cultural and spiritual considerations into the client's discharge plan.
- Add cultural and spiritual categories into the Treatment Plan matrix, include goals, objectives and interventions which are culturally and spiritually driven according to the client's orientation and desires.
- Develop a policy to encourage discharge planning which is pro-active in finding placements on Indian Reservations for those clients who identify themselves as native and have tribal affiliations.
- Actively recruit staff from diverse cultural/racial/ethnic groups and in particular, Native American staff.
- Add more culturally diverse activities on campus, and particularly emphasize Native American events and cultural skills (such as Native crafts and games).
- Actively encourage all clients to consider their own spiritual orientation and encourage development in that area as important to whole person integration. Actively offer and provide support for spiritual exploration, learning, and practices for each individual served

## Staff Competence, Training, Supervision, and Relationships with Clients

### *Competence and Training:*

**Position Descriptions for staff positions at MDC are being rewritten to include detailed information: Work Unit Mission Statement or Functional Description, Major Duties and Responsibilities, Description of Job Purpose, Minimum Qualifications, Behaviors Required to Perform Duties, Education and Experience Required, and other important job information.**

**The training curriculum focuses on new staff achieving optimum knowledge and competence. Staff pre-service orientation training is two weeks long. The pre-service training curriculum includes basic information about intellectual disability and mental illness with an introduction to medications used to treat mental illness. Each new staff member must successfully complete a final exam to conclude the pre-service training. To complete pre-service training, new staff must successfully complete the following: a six month probationary period, a minimum of 2000 hours as a paid trainee, 23 mandatory classes and 5 pre-service training classes.**

**Staff members are supported to complete continuing education, including attending NADD[2] Conferences, Department of Public Health and Human Services trainings, and professional conferences. MDC pays for nursing staff to attend continuing education programs which relate to improving quality of care for the individuals served. One nurse described great flexibility in her scheduling to allow for the continuing education needed for her to transition from an associate's degree to a baccalaureate degree in nursing. A goal noted by staff in the nursing department is that nursing staff will be able to complete a psychiatric nurse certification program. The position description for the Registered Nurse indicates a minimum of a Bachelor's degree. At the time of the site review, not all RNs on staff had this level of education.**

**A detailed training certification report for each staff member was supplied to the BOV team. Verification that scheduled training has been completed is detailed by name of staff, training completion date and expiration of certification dates. Assessment of staff to address knowledge and competence deficiencies is done at the weekly What Works meetings and as needed.**

**MDC is to be commended for their recognition of the potential for staff burnout and for their plan to initiate Trauma Informed Training to assist staff in developing personal stress management care plans and for supporting nursing continuing education.**

**All MDC employees receive training from training officers certified by the Mandt System[3]. Mandt® is a nationally accepted program focused on how to develop appropriate interactions with individuals served. The training is given to all new staff employees who work directly with clients as well as administrative personnel. Continuing Mandt® education is required each year.**

**Information gathered by the team suggests that an additional level of boundary training is needed for employees who "float" to the ASU. Staff interviewed noted that Individuals residing at the ASU may require higher levels of staff training and skills and often the least experienced staff may be assigned to the ASU.**

**Suggestions:**
**Assure that RN position descriptions describe correctly whether a Bachelor's degree is a minimum requirement or preferred requirement as a qualification.**

**Provide additional training for nurses who are transitioning from a Licensed Vocational Nurse (LVN) status to a RN; these roles have differing scope of practice.**

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[2] NADD: An Association for Persons with Developmental Disabilities and Mental Health Needs
http://thenadd.org/
[3] The Mandt System®
http://www.mandtsystem.com/

## *Supervision:*

Strengths/Observations:
A training program specific to supervisory duties is a work in progress. A workgroup has been appointed to prepare a training module for shift managers. This same workgroup is working toward a process to evaluate supervisor skills using performance appraisals which will identify areas for further supervisor focused training.

Supervisors monitor treatment plan implementation and evaluate staff knowledge about the details of each treatment plan, including staff member roles for implementing treatment goals for each individual served. Supervisors indicated that "Safe Haven" and "What Works" are processes used to monitor and oversee that staff are implementing treatment plans consistently. Staff remarked that the debriefing and training provided at those meetings is valuable and effective.

An updated format for appraising staff performance was introduced in 2011 and continues to be refined. This format will allow staff to set annual goals for professional development and performance improvement. Appraisals for supervisors include objectives to define expectations for additional training and leadership development. BOV reviewed the performance appraisal format and observed that the process does not yet consistently provide the opportunity for staff to discuss adjustments in the work environment that would improve job performance.

Many of the staff interviewed mentioned stress as a job related concern, a few suggested that training about compassion fatigue would be beneficial to address the emotional and physical demands of working at MDC.

Suggestions:
Consider adding a module to continuing education offerings about compassion fatigue.

## *Relationships with Clients:*

### Active Engagement

Strengths/Observations:
Education about mental illness has been integrated into new employee orientation/pre-service training. The emphasis on mental health education appears to be universally accepted as beneficial to staff. A number of staff were able to articulate that having information to help them understand why behaviors happen. Staff can recognize mental illness and respond to behaviors more therapeutically. Two days have been added to orientation so new hires now receive 12 days of pre-service training. Staff voiced concern that training for therapeutic boundaries is an on-going need and requested more training in that area.

The benefit to staff of the additional pre-service training was apparent during the site review. BOV observed evidence of staff partnering with individuals served in treatment rather than the treatment being applied to the individual. Staff on the units generally demonstrated respect and caring while maintaining a sense of professionalism when interacting with individuals served.

Staff expressed a genuine belief that incidents of physical and verbal aggression are declining, incidents of restraint have declined, and that there are fewer grievances and allegations of abuse/neglect. Although the Quality Assurance Department did not have complete data to support the statements, the comments illustrate a shift of perspective among staff interviewed. In 2010 a majority of the staff expressed a pessimistic and negative attitude about safety for staff and individuals served.

Suggestions:
Continue focusing on supervision that ensures professional staff is consistently in treatment environments interacting with staff and individuals served; providing in the moment education, while modeling and reinforcing healthy, constructive and respectful interactions.

## Treatment and Support

### *General:*

The treatment planning process begins at admission to MDC. A complete nursing assessment and physical evaluation is completed by a registered nurse immediately, and the medical director reviews the findings. A nurse collects a medical history then evaluates health, nutritional needs and need for dental care. The psychiatrist performs an evaluation within four days of admission to evaluate medical conditions which may be responsible for presenting psychiatric symptoms. After diagnosis, the psychiatrist provides education to the individuals served and family members/guardians about the diagnosis, medications that will be prescribed, and options for treatment.

MDC introduced a new Individual Treatment Plan (ITP) format in 2011 to meet requirements for active treatment. ITP plans are simple to read and follow, are based on interdisciplinary assessments and clearly identify which staff members are responsible for completing the treatment goals with the individuals served. Identifying and treating symptoms and behaviors that resulted in the individual served being admitted to MDC is the focus of treatment. The safe, successful transition back into the community is the ultimate goal of the ITP and treatment process.

MDC policy requires that the treatment planning process includes staff from all disciplines, the individual served. Family member/guardian involvement is strongly encouraged.

### *Evidence-Based Services:*

Strengths/Observations:

MDC is providing treatment and support to adults in a manner that is consistent with Substance Abuse and Mental Health Service Administration[4] (SAMHSA) principles for recovery. SAMHSA recommends that treatment plans incorporate evidence-based practices consistent with principles for recovery; the ITP is providing that framework. Plans include treatment objectives for individuals who have identified cognitive disabilities with co-occurring psychiatric and substance use disorders. The clinical director, the psychiatrist, and the therapists interviewed indicated good knowledge and use of currently-accepted evidence-based and trauma-informed care practices.

Trauma-informed care recognizes the presence of trauma symptoms and acknowledges the impact of trauma on individuals as part of the treatment planning process. There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in treatment and recovery settings as a universal standard of care. Since 2011 MDC has emphasized staff training on the SAMHSA principles of trauma-informed care as an approach to providing treatment to individuals served.

Supported employment goals are established in treatment plans to prepare individuals for transition to community-based services. Education, vocational training, and on-the-job experience are goals in most treatment plans to assure individuals served have the life skills, job skills and work experience needed to be successful when they move to the community.

The team observed that treatment planning may be improved if each individual being admitted has recently received a neuropsychological evaluation assessing brain function and learning capacities from a doctoral-level licensed practitioner. This evaluation will provide needed information regarding how the individual can learn coping skills. Educate staff about each individual's learning style strengths and weaknesses and actively assist staff to understand interventions which will best support the client to learn the necessary new skills. When the treatment plan is reviewed, especially consider whether or not the current interventions used are effective and if not, consider alternative modes of teaching necessary coping skills.

Suggestions:

The new ITP format has 4 "problem statements." Consider splitting problem #2, concerning diagnosis, into two divisions--one to address cognitive issues and one to address the other diagnosed psychological disorders on Axis I and II.

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[4] Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov/index.aspx

Assure that participants in the assessment and treatment planning meeting are listed on the treatment plan form. Indicate who is responsible for the diagnosis being given, and that a diagnosis is being determined by a licensed mental health professional and not by a case manager.

Assure that substance-abuse disorders are being identified through assessment with treatment options included in treatment plans.

## *Medication:*

Strengths/Observations:
Medication protocols appear to be based on the most current evidence. MDC has recently hired a psychiatrist who is on-site 20 hours a week; an increase from previous psychiatric services. Additionally, both the prescribing psychiatrist and the medical doctor provide coverage by phone as needed. The rationale for prescribing and/or changing medications is documented in the psychiatric and medical records. Family members/guardians are notified about medication prescription changes by the psychiatrist or medical doctor.

The LVN or the RN is responsible for promoting adherence to medications. Nursing staff encourage and negotiate with individuals served for medication compliance as it is needed. Individuals served receive education about the use and side effects of their medication by the physician and information is reinforced by the nursing staff. Nursing staff will listen to concerns voiced by individuals about the medications they receive and continually provide education about the benefits of the medication and the potential impact of suddenly discontinuing a medication. Ultimately, the nurse recognizes that the resident has the right to refuse a medication. Physicians are notified when a resident refuses medication. Documentation of the missed medication is reported on the Medication Administration Record (MAR), THERAP®, and in the log book. Support or access to treatment is not withdrawn if an individual served does not adhere to medications. All medication deliveries are provided by nursing staff to individuals at each of the units.

Nursing staff report that access to the psychiatrist is assured as soon as concerns about medications and adverse reactions are identified. These reactions are documented in the nurse's notes. Staff also report that the psychiatrist educates the staff regarding monitoring for side-effects.

Information about monitoring individuals taking antipsychotic medication is documented in the physician's notes. The Laboratory Test Protocols for MDC include the baseline and follow-up labs indicated for individuals receiving antipsychotic medication. MDC is meeting and in some cases exceeding recommendations set forth by The American Psychiatric and Diabetes Association. Nursing staff assess for extrapyramidal[5] symptoms (EPS) at least quarterly and more often, as needed.

MDC has an inclusive policy and procedure for documenting medication errors (see ATD 701.14). The Director of Nursing (DON) reports that this procedure is followed and that the Quality Improvement process in place has resulted in a change in the environment and/or process of administration of medications. As a result medications errors have decreased.

Standing medical orders for PRN medications related to managing pain, elevated temperature, colds and coughs, acute asthma, skin and lip conditions, seizures, chest pain, digestive difficulties, and nicotine replacement therapy are in place. PRN medication usage for behaviors is appropriately monitored and documented. Nursing staff report that the process to determine the PRN medication use is very individual and that, while the least restrictive interventions are always used first, the safety of the individual and those around him/her are also considered. The nurse who is responsible for the particular living area makes the decision about the use of PRN medications and records when they are used on THERAP®, MAR, and in the log book.

Medication samples are not used at MDC. Unused or expired medications are placed in a secure box and are collected by the pharmacist weekly.

Suggestions:
Expedite the completion of the security system in the clinic so medications in the clinic are housed in one secure location.

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[5] Extrapyramidal Symptoms
http://www.medicalnewstoday.com/releases/13702.php

## Access and Entry

Strengths/Observations:
Individuals enter services at MDC through emergency admission and court commitment. Court commitments are made on the recommendation of the Residential Facility Screening Team (RFST). Emergency Admissions may be made by a professional person for no more than thirty days under 53-20-129, MCA. If the RFST concludes an individual is seriously developmentally disabled and meets the criteria for admission, it will file a request with the court to order commitment to MDC.

The Client Services Coordinator organizes the intake process and serves as the single point of contact for family members/guardians. A nurse completes an admission assessment using standard nursing protocol. Outside treatment is not allowed once an individual is transferred to MDC except to provide support to the individual during the transition into the facility. A General Admissions Procedure Form outlines the facility's duties and responsibilities for services and treatment while the individual is at the facility. Each individual receives a handbook of information about MDC that includes an explanation about individual rights and responsibilities at the facility. Family members/guardians receive information about their rights and responsibilities while their family member is receiving services at MDC.

Suggestions:
Update the General Admission Procedure (ATD 104.1) and/or other forms to reflect that MDC has an on-site Psychiatrist and clarify whether the psychiatrist sees the clients during the intake process or shortly thereafter.

Include an assessment of spiritual, cultural/racial, and trauma experience considerations in the intake assessment process.

## Continuity of Services through Transitions

Strengths/Observations:
Client Service Coordinators manage the discharge planning efforts for an individual's transition back to the community. BOV observed that in some transitions, MDC staff did not assume responsibility to assure a smooth transition, and did not take the lead for implementing the transition.

MDC does not appear to have a specific formal protocol for staff members to follow up with community providers when an individual moves into their services. Follow-up appears to be informal and sometimes haphazard. Staff reported that community providers know they can contact MDC if they have problems, concerns, or questions. Service providers reported that the most successful transitions occur when MDC staff familiar with the individual served accompanies that person to the community program, and stays through an initial orientation to the new program. This does not always occur.

Community-based service providers have requested more detailed information about the individuals moving into their services from MDC. Providers expressed concern that the transition process has recently been abbreviated and the information they receive about individuals is not adequate. Service providers want a complete treatment plan that includes a summary of behavioral goals, objectives and interventions; a description of the degree to which each goal was achieved; and, suggestions for ongoing behavioral treatment within the new program.

The individual served leaves the facility with medication to last 30 days. The client services coordinator is responsible for obtaining medications for the uninsured or underinsured clients at discharge. Psychiatric and medical appointments are arranged by the community service provider.

Suggestions:
To assure a successful transition, MDC staff who accompany individuals served should be familiar with the individual, able to provide specific information to the community provider, and accompany the individual through an orientation to the services.

During transition assure that the community provider is aware of the presence of a co-occurring substance abuse issue if one exists.

# RECOMMENDATIONS

1. Establish a process for communicating with families/guardians that identifies the type of information families/guardians want to receive; who will be responsible for contact; and, how the contact will be documented. The process should identify supervisor responsibilities for assuring MDC staff is communicating with families/guardians.

2. Update the current training and readiness evaluation process to assure that all employees have a level of skill and training, including boundaries training, sufficient so they can work safely at any unit on campus.

3. Establish a model to consistently debrief staff after allegations of abuse and/or neglect are substantiated.

4. Design a section in the ITP matrix to include spiritual, cultural/racial, and trauma experience categories to be addressed by the treatment plan.

5. Develop a transition communication process to provide community service providers a complete treatment plan that includes a summary of behavioral goals, objectives and interventions; a description of the degree to which each goal has been achieved; and, suggestions for ongoing behavioral treatment within the new program.

6. For quality assurance purposes, create a survey instrument and contact community based providers to survey them about their experience when an individual is transitioned into those services.

# MONTANA DEVELOPMENTAL CENTER
## DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

BRIAN SCHWEITZER
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December 27, 2012

Alicia Pichette, Executive Director
Mental Disabilities Board of Visitors
PO Box 200804
Helena, Montana 59620-0804

Ms. Pichette:

Thank you very much for the draft of the site review report for the Board of Visitors' review of services at the Montana Developmental Center conducted by the Board on November 1 and 2, 2012. We greatly appreciated the opportunity this review presented for our staff to discuss current services, ongoing projects for improvement, and plans for continuing improvement.

I also want to acknowledge and thank you for your insightful analysis, suggestions, and recommendations. We embrace the Board's perspective and value its feedback. The Board hasn't requested that we respond to plans for implementation of the report's "suggestions" – only the recommendations. However, in addition to the specific plans for implementation of the recommendations included in the enclosed report, we fully intend to implement all of the suggestions also. We see all of the Board's ideas as valuable guidance that will enhance our improvement efforts.

Sincerely,

Gene Haire, Superintendent
Montana Developmental Center

# MDC RESPONSE to RECOMMENDATIONS

Establish a process for communicating with families/guardians that identifies the type of information families/guardians want to receive; who will be responsible for contact; and, how the contact will be documented. The process should identify supervisor responsibilities for assuring MDC staff is communicating with families/guardians.

*MDC Response:*
*The MDC Residential Services Director will work with the QMRPs and Client Services Coordinators to establish a process for communicating with families/guardians that identifies the type of information families/guardians want to receive; who will be responsible for contact; and, how the contact will be documented. This information will be organized on Therap for each client/family. This process will identify supervisor responsibilities for assuring MDC staff is communicating with families/guardians. The Client Service Coordinators will be responsible for ensuring that communication with families follows this process. The QMRPs will be responsible for ensuring that this process is followed.* Target Date: 3/1/13

Update the current training and readiness evaluation process to assure that all employees have a level of skill and training, including boundaries training, sufficient so they can work safely at any unit on campus.

*MDC Response:*
*The MDC Residential Services Director will work with the QMRPs, Unit Coordinators, and the Staff Development Specialist to update the current training and readiness evaluation process to assure that all employees have a level of skill and training, including boundaries training, sufficient so they can work safely at any unit on campus. The Staff* Development *Specialist will be responsible for ensuring that this training and readiness evaluation process is followed.* Target Date: 3/1/13

Establish a model to consistently debrief staff after allegations of abuse and/or neglect are substantiated.

*MDC Response:*
*The MDC Quality Management Director will work with the Client Protection Specialist, the Clinical Director, the Residential Services Director, and the Treatment Services Director to establish a model to consistently debrief staff after allegations of abuse and/or neglect are substantiated. The Quality Management Director will be responsible for ensuring that debriefings occur.* Target Date: 2/15/13

Design a section in the ITP matrix to include spiritual, cultural/racial, and trauma experience categories to be addressed by the treatment plan.

*MDC Response:*
*The Clinical Director will work with the Treatment Division to incorporate spiritual, cultural/racial, and trauma experience categories into the individual treatment plan.* Target Date: 3/1/13

Develop a transition communication process to provide community service providers a complete treatment plan that includes a summary of behavioral goals, objectives and interventions; a description of the degree to which each goal has been achieved; and, suggestions for ongoing behavioral treatment within the new program.

*MDC Response:*
*The Clinical Director will work with the Treatment Division to develop a transition communication process to provide community service providers a complete treatment plan that includes a summary of behavioral goals, objectives and interventions; a description of the degree to which each goal has been achieved; and, suggestions for ongoing behavioral treatment within the new program.*
Target Date: 3/1/13

For quality assurance purposes, create a survey instrument and contact community based providers to survey them about their experience when an individual is transitioned into those services.

*MDC Response:*
*The Quality Management Director will create a survey instrument and contact community based providers to survey them about their experience when an individual is transitioned into those services.* Target Date: 2/15/13

**DSD Caseload Adjustment Decision Packages**

**PL 10201 - Med Ben Core Services Caseload Children's MH**

- This present law adjustment for caseload growth in the Developmental Services Division covers the increase in the number of eligible people, utilization, acuity level, and cost per service for medical care. The request is for $3,024,142 general fund and $4,508,699 federal funds for FY 2014 and $4,571,317 general fund and $6,446,581 federal funds in FY 2015.

| Fiscal Year | General Fund | State Special | Federal Funds | Total Request |
|---|---|---|---|---|
| FY 2014 | $ 3,024,142 | $ - | $ 4,508,699 | $ 7,532,841 |
| FY 2015 | $ 4,571,317 | $ - | $ 6,446,581 | $ 11,017,898 |
| Biennium Total | $ 7,595,459 | $ - | $ 10,955,280 | $ 18,550,739 |

This DP covers the Medicaid Caseload adjustment for Entitled services except for i-home. I-home was not included in this DP because at the time the DP's were submitted, i-home had not become a state plan service and the services were still being delivered under the waiver. The projections for this DP already include a reduction to account for the projected i-home services in the amounts of $2,246,973 in FY 2014 and $3,554,556 in FY 2015. The DP includes the following:

CMH – State Plan Medicaid Services

| Fiscal Year | General Fund | State Special | Federal Funds | Total Request |
|---|---|---|---|---|
| FY 2014 | $ 2,835,501 | $ - | $ 4,208,429 | $ 7,043,930 |
| FY 2015 | $ 4,338,639 | $ - | $ 6,111,025 | $ 10,449,664 |

DD – State Plan Medicaid – Case Management

| Fiscal Year | General Fund | State Special | Federal Funds | Total Request |
|---|---|---|---|---|
| FY 2014 | $ 188,641 | $ - | $ 300,270 | $ 488,911 |
| FY 2015 | $ 232,678 | $ - | $ 335,556 | $ 568,235 |

This DP, PL 10201 is the result of an increase in people eligible for these entitlement programs and an increase in utilization of services available. The CMH program has been seeing increases in close to 1000 eligible kids accessing services each year. DD has been seeing an increase of individuals on the Wait List, which makes them eligible for Case Management.

**PL 10202 - Med Ben Waiver Services Caseload Dev Dis**

- This present law adjustment for caseload growth in the Developmental Services Division covers the increase in the number of eligible people, utilization, acuity level, and cost per service for medical care. The request is for $4,103,138 general fund and $8,061,516 federal funds for FY 2014 and $5,266,621 general fund and $10,324,321 federal funds for FY 2015. LFD Budget Analysis page **B-118.**

| Fiscal Year | General Fund | State Special | Federal Funds | Total Request |
|---|---|---|---|---|
| FY 2014 | $ 4,103,138 | $ - | $ 8,061,516 | $ 12,164,654 |
| FY 2015 | $ 5,266,621 | $ - | $ 10,324,321 | $ 15,590,942 |
| Biennium Total | $ 9,369,759 | $ - | $ 18,385,837 | $ 27,755,596 |

This DP covers the Caseload adjustment for all Waiver programs in the division, and includes the i-home projection because the i-home activities were still covered under the waiver when the DP was submitted. This DP includes the following:

CMH – i-home services

| Fiscal Year | General Fund | State Special | Federal Funds | Total Request |
|---|---|---|---|---|
| FY 2014 | $ 772,509 | $ - | $ 1,474,464 | $ 2,246,973 |
| FY 2015 | $ 1,236,985 | $ - | $ 2,317,571 | $ 3,554,556 |

Developmental Disabilities Waiver Programs

| Fiscal Year | General Fund | State Special | Federal Funds | Total Request |
|---|---|---|---|---|
| FY 2014 | $ 3,409,699 | $ - | $ 6,507,982 | $ 9,917,681 |
| FY 2015 | $ 4,188,662 | $ - | $ 7,847,724 | $ 12,036,386 |

There are very specific services represented in this DP.

First, the utilization of i-home services that are now available under state plan instead of under the PRTF waiver are represented here. The individuals receiving i-home services are not new to Children's Mental Health, the projection of i-home is cost neutral overall because in most cases the children are expected to access the i-home services instead of other State Plan services. The i-home portion of the DP equally offsets with these services in PL10201 to accomplish the cost neutrality.

The DD Waiver expenses are a combination of:

1.) An average of 24 individuals per year eligible to leave MDC. Average cost plans are close to $120,000 per year for these individuals and the average number of individuals ready to leave has been 24 in recent years.
2.) Utilization of Individual Cost Plans (ICP's) being less than 100%. The DD Program budgets a set amount per individual for the ICP. If they do not use 100% of their funding, they are still entitled to that funding the next year. It is very unusual for an individual to use 100% of their funding. The ICP amounts for each individual are restored to 100% in the Caseload Adjustment process every biennium.
3.) The ongoing effects of refinancing. There are individuals who are still completing the refinancing process to become Medicaid eligible and receive their DD services under Medicaid. The refinancing process was more successful than the Program anticipated and more individuals were able to become Medicaid eligible. This caused a larger shift from Non-Medicaid funded services to Medicaid funded services. You are seeing only the Medicaid side of the shift in this DP, the Non-Medicaid Reduction was part of the Refinancing DP processed last session. The Refinancing activities did not include a request to reduce the number of Waiver slots so vacated slots were filled by Medicaid eligible individuals. Many screenings took place late in FY 2012 for refinancing slots. This caused expenditures in FY 2012 show an artificially low utilization percent. This DP corrects the utilization, while maintaining the number of waiver slots that were affected by refinancing. Refinancing is expected to be completed no later than June 30, 2013.

**PL 10203 - Med Ben Federal Only Caseload Dev Dis**

- This present law adjustment for caseload growth in the Children's Mental Health program covers the increase in the number of eligible people, utilization, acuity level, and cost per service for mental health care. The request is for $4,813,949 of federal funds in FY 2014 and $7,580,458 of federal funds in FY 2015. LFD Budget Analysis page **B-120.**

| Fiscal Year | General Fund | State Special | Federal Funds | Total Request |
|---|---|---|---|---|
| **FY 2014** | **$** | **$ -** | **$ 4,813,949** | **$ 4,813,949** |
| **FY 2015** | **$** | **$ -** | **$ 7,580,458** | **$ 7,580,458** |

This DP is Comprehensive School and Community Treatment for Mental Health only (CSCT). These are the federal match funds

MONTANA DPHHS

*Healthy People. Healthy Communities.*

Department of Public Health & Human Services

**Recruiting Status Definitions:**

Initial - The request to fill has been submitted however, the position is not yet advertised.

Recruiting - The position is currently advertised.

Screening - The process of screening appicants, interviewing, reference checks, etc.

Filled - An employment offer has been made and accepted. SABHRS HR data, does not yet reflect the hire.

## HB 2 Reg Vacant FTE as of 1-18-13

| Division | Position | Descr | FTE | Vacancy Date | Days Vacant | Location | Recruiting Status | Additional Information |
|---|---|---|---|---|---|---|---|---|
| Developmental Services Division | | | | | | | | |
| | 69111705 | State Wraparound Coordinator | 1.00 | 12/15/2012 | 33 | Great Falls | Screening | |
| | 69111706 | Regional Program Officer | 1.00 | 2/13/2012 | 335 | Helena | Filled | Start Date 01/28/13 |
| | 69111708 | Budget Analyst | 1.00 | 12/29/2012 | 19 | Helena | Screening | |
| | 69111712 | Qualitative Data Analyst | 1.00 | 5/19/2012 | 239 | Helena | Filled | Start Date 01/28/13 |
| | 69111713 | Clinical Supervisor | 1.00 | 1/28/2012 | 350 | Helena | Filled | Start Date 01/28/13 |
| | 69151112 | Medical Health Services Mgr | 1.00 | 11/3/2012 | 75 | Boulder | | |
| | 69151186 | Cook | 1.00 | 4/7/2012 | 281 | Boulder | Filled | Offered and accepted |
| | 69151192 | Food Preparation Worker | 1.00 | 5/5/2012 | 253 | Boulder | Filled | Offered and accepted |
| | 69151200 | Custodian | 1.00 | 12/3/2012 | 45 | Boulder | Filled | Offered and accepted |
| | 69151257 | Maintenance Worker | 1.00 | 10/8/2011 | 460 | Boulder | Filled | Offered and accepted |
| | 69151362 | Qualified M Retardation Prof | 1.00 | 4/7/2012 | 281 | Boulder | Recruiting | |
| | 69151431 | Speech Pathologist | 1.00 | 12/1/2012 | 47 | Boulder | | |
| | 69151512 | LPN | 1.00 | 9/22/2012 | 116 | Boulder | | |
| | 69151517 | LPN | 1.00 | 8/11/2012 | 157 | Boulder | | |
| | 69151518 | Occupational Therapist | 1.00 | 2/25/2012 | 323 | Boulder | Recruiting | |
| | 69151576 | Treatment & Program Spec | 1.00 | 6/30/2012 | 198 | Boulder | Screening | |
| | 69151661 | Shift Manager | 1.00 | 1/19/2013 | -1 | Boulder | | |
| | 69151698 | Psychiatric Aide | 1.00 | 12/22/2012 | 26 | Boulder | | |
| | 69151760 | Psychiatric Aide | 1.00 | 1/12/2013 | 6 | Boulder | | |
| | 69151843 | Treatment & Prog Specialist | 1.00 | 12/1/2012 | 47 | Boulder | | |
| | 69190086 | Child Protection Specialist | 1.00 | 8/25/2012 | 143 | Boulder | Recruiting | |
| | 69195101 | Food Service Worker | 0.19 | 1/1/2011 | 737 | Boulder | Filled | Offered and accepted |
| | 69114112 | Quality Improvement Spec | 1.00 | 10/20/2012 | 88 | Missoula | Screening | |
| | 69114182 | Quality Improvement Spec | 1.00 | 12/29/2012 | 19 | Helena | | |
| | 69114388 | DD Case Manager | 1.00 | 6/30/2012 | 198 | Helena | Screening | |
| | 69114481 | Quality Improvement Specialist | 1.00 | 9/8/2012 | 130 | Billings | Recruiting | |
| | 69114496 | DD Case Manager | 1.00 | 1/12/2013 | 6 | Billings | | |
| | 69114673 | Rehabilitation Counselor | 1.00 | 11/3/2012 | 75 | Helena | | |
| | | | 27.19 | Total FTE | | | | |